State of Utah
SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Insurance Department

JONATHAN T. PIKE
Insurance Commissioner

2022 Utah Health Insurance Market Report

The *2022 Utah Health Insurance Market Report* was prepared by Jeffrey E. Hawley, Ph.D. of the Health & Life Insurance Division for the Utah Insurance Commissioner pursuant to Utah Code § 31A-2-201.2. Publication date: December 1, 2022.

For questions about this report contact:

Jeffrey E. Hawley, Ph.D.
Research Consultant
Health & Life Insurance Division
Utah Insurance Department
4315 S. 2700 West, Suite 2300
Taylorsville, Utah 84129
801-957-9284
jhawley@utah.gov

Shelley Wiseman, MPA
Director
Health & Life Insurance Division
Utah Insurance Department
4315 S. 2700 West, Suite 2300
Taylorsville, Utah 84129
801-957-9296
swiseman@utah.gov

Table of Contents

List of Tables

List of Figures

Executive Summary

Health insurance is an important issue for the people of Utah. Utah's residents receive their health insurance coverage through health plans sponsored by the government, employers, and commercial health insurers. The commercial health insurance market is the only source of health insurance directly regulated by the Utah Insurance Department, hereafter referred to as the Insurance Department for the purposes of this report.

Approximately 38 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). Comprehensive health insurance membership as a percentage of Utah residents continues to decline and the comprehensive health insurance industry serves about 22 percent of Utah residents. The typical policy in this industry is an employer group policy with a managed care plan administered by a domestic commercial health insurer.

A key function of the Insurance Department is to assist consumers with questions and concerns they have about insurance coverage. The Office of Consumer Health Assistance (OCHA) is the agency within the Insurance Department that handles consumer concerns about their health insurance.

The total number of consumer complaints received by the Insurance Department increased from 2012 to 2016, declined from 2017 to 2020, and then increased during 2021. Consumers continue to contact the Insurance Department in significant numbers. The number of consumer complaints increased during the early implementation of the ACA, but has started to decline towards pre-ACA levels. During 2021, the number of complaints increased by 21 percent. Another important trend over the last seven years has been an increase in the number of complaints related to the issue of balance billing, where a health care provider bills the patient for the difference between the provider's charge and the amount paid by health insurance. Balance billing complaints accounted for about 10 percent of all consumer complaints from 2015 to 2017, about 16 percent during 2018, about 8 percent during 2019, about 10 percent during 2020, and about 6 percent during 2021. In response to this pattern in Utah and other states, the federal government passed the No Surprises Act. This new law addresses the issue of balance billing and provides consumer protections for surprise medical billing. This federal law applies to individual and group health benefit plans and took effect on January 1, 2022.

In addition to consumer complaints, the Insurance Department receives and processes requests from consumers for an independent review of their denied claims by an Independent Review Organization (IRO). The number of independent reviews remained relatively stable from 2012 to 2014, increased during 2015 and 2016, remained stable during 2017, increased during 2018, and then declined during 2019 to 2021. From 2020 to 2021, the number of requests for independent reviews decreased by about 7 percent.

Over the last ten years, there have been four significant trends in the comprehensive health insurance market that the Insurance Department continues to monitor: changes in the number of insurers, the number of Utah residents with comprehensive health insurance, the cost of comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers declined from 2012 to 2020. During 2021, the number of comprehensive health insurers increased. The decline from 2012 to 2020 has primarily been due to a decrease in the number of small and very small foreign comprehensive health insurers. In contrast, while there has been some shifting within the market as part of the full implementation of the ACA including health insurers leaving the market, the total number of large insurers has generally remained stable. Large domestic comprehensive health insurers continue to account for more than 85 percent of the market. The number of medium insurers has fluctuated during this period. Financial stress and regulatory uncertainty in the market have made it difficult for some insurers to participate in the comprehensive market and to sustain participation in the Federally Facilitated Marketplace (FFM). From 2014 to 2021, there has been some market shifting including several new insurers that entered the market to participate in the Federally Facilitated Marketplace (FFM). Recent improvements in premium income and market stability have made it easier for health insurers to participate. Six comprehensive health insurers participated in the FFM during 2021.

From 2012 to 2021, the number of Utah residents covered by comprehensive health insurance as a relative percentage of Utah's population has declined by about 5.4 percent. Comprehensive health insurance membership has averaged about 765,000 members over the last 10 years. During 2021, comprehensive membership increased by about 5.4 percent. This increase appears to be due to changes in the individual and small group markets.

From 2014 to 2016, membership in the individual market grew significantly. Most of this growth was driven by the federal individual mandate which required most persons to maintain health insurance, the availability of coverage through the FFM, where persons whose income is between 100 percent and 400 percent of the federal poverty level receive subsidies to make coverage more affordable, and changes to health insurance regulations, including guaranteed issue and community rating, which have made it easier for Utah residents to get and keep coverage in the individual market.

During 2017, the individual market declined by over 32,000 members. This decline occurred among individuals with Off-Exchange plans who pay the full cost of any premium increases in the individual market and do not receive any subsidies under the ACA to make coverage more affordable. Membership in FFM plans, where most members have premium subsidies, did not experience the same change. Consumers and health insurers were experiencing significant market uncertainty during 2017, such as the question of how rising health care costs and changes to government regulations and the ACA would affect consumers, as well as the ending of Cost-Sharing Reduction (CSR) payments and the possibility of the repeal of the ACA. During 2018, membership in the individual market remained stable, followed by an increase of over 11,000 members during 2019 and 2020. This change appears to be due to steady growth in FFM membership and the availability of enhanced Advance Premium Tax Credit (APTC) payments during this period.

During 2021, membership in the individual market increased significantly. The number of members in the individual market, driven by growth in FFM membership, increased by more than 35,000. This growth appears to be related to the American Rescue Plan Act of 2021 (ARPA). The APRA was designed to assist persons effected by the COVID-19 pandemic, which

includes expanded premium tax credits for individuals who are eligible for the FFM and also offers subsidies to persons with incomes greater than 400 percent of the federal poverty level. The ARPA provisions are temporary and were scheduled to last until the end of 2022 but have been extended through 2025 under the Inflation Reduction Act of 2022.

Membership in the small group market declined from 2016 to 2019. This decline in small group membership followed premium increases in the small group market during this period. It is also possible that some small group membership may have shifted to the individual market, and healthy small groups have moved to self-funded health benefit plan arrangements to circumvent several of the ACA provisions. Small group market membership remained stable during 2020 and then increased during 2021 to a level similar to 2018. The number of members covered by stop-loss policies that were issued to small group self-funded plans increased during this period.

Large group membership declined from 2014 to 2016, remained stable during 2017, and then declined from 2018 to 2021. This change appears to be due to some employer groups moving to self-funding arrangements, although one cannot rule out the possibility of some shifting to the individual market.

Comprehensive health insurance premium per member per month increased slightly from 2020 to 2021. The average premium per member per month increased from $386 during 2020 to $388 during 2021, an increase of 0.5 percent. The small change in premiums was primarily due to comprehensive health insurers setting rates in the individual and small group markets at levels similar to or slightly lower than 2020. Over the last ten years, increases in comprehensive premium per member per month have averaged 5.1 percent per year, while increases in losses per member per month have averaged 5.6 percent per year.

From 2014 to 2016, comprehensive health insurers reported high loss ratios, as premiums, even after payments from the various reinsurance and risk adjustment programs under the ACA, were not sufficient to cover the healthcare costs of their insured members. The shift to ACA compliant plans, changes in rating methods, and expanded coverage for higher risk individuals, combined with lower than expected payments from the federal risk corridor program, all contributed to these higher loss ratios. Comprehensive health insurers in both 2014 and 2015 had limited claim history to work with to produce reasonable projections, were unable to underwrite for insurance risk on an individual basis, and 2014 rates were set prior to the creation of “transitional plans” which prevented insurers from making rate adjustments prior to 2014. During 2016, comprehensive health insurers had more claim experience to work with, but there was still considerable market uncertainty which made pricing their products more difficult. During 2017, health insurers had more accurate pricing information and implemented higher rates that more precisely represented their actual risk experience and this resulted in improved loss ratios in the individual market. During 2018, the combination of more accurate pricing information and the elimination of the CSR payment program by the federal government in October 2017 required health insurers to significantly raise premium rates. The higher premiums collected during 2018 improved loss ratios in the individual market, allowing health insurers to cover the cost of health care services that they were paying out for their members. During 2019,

comprehensive premiums remained stable as comprehensive health insurers maintained the rate increases set during 2018.

During 2020, comprehensive health insurers were impacted by the COVID-19 pandemic. In the spring of 2020, health care spending declined as consumers reduced elective health care to preserve hospital capacity and implement social distancing measures. Although other forms of health care spending increased, the net impact of the COVID-19 pandemic appears to have kept health care spending and comprehensive premiums stable during 2020.

During 2021, comprehensive health insurers experienced uncertainty as to how the COVID-19 pandemic would affect the insurance market. Comprehensive health insurers responded to this uncertainty by setting rates in the individual and small group markets at levels similar to or slightly lower than 2020. Comprehensive health insurers in the individual market reported lower premium per member per month, but experienced higher loss ratios. Comprehensive health insurers in the large group market reported higher premium per member per month, but did not report higher loss ratios.

Comprehensive health insurers, whether for-profit or non-profit, need enough income after expenses to fund state-mandated reserve requirements, reinvest in new equipment and new markets, and acquire and maintain needed capital. The top insurers in the comprehensive health insurance industry have experienced an average financial gain of 2.3 percent in net income after expenses over the last ten years, with top comprehensive health insurers reporting an average gain of 4.0 percent in net income after expenses during 2021.

The first three years of the full implementation of the ACA were financially difficult for Utah's core comprehensive health insurers. Comprehensive health insurers had a limited claim history to work with and were unable to generate enough premium income to cover their losses. Changes to the federal risk corridor program meant comprehensive health insurers did not receive the additional payments that were expected under the program that would have helped them cover their costs.

From 2014 through 2016, the combination of not having enough information to adequately price their products and not receiving the additional payments from the federal risk corridor program as expected produced higher losses for health insurers participating in the individual market and the FFM. Several comprehensive health insurers withdrew from the FFM due to concerns that these losses were not sustainable.

During 2017, the fourth year of the full implementation of the ACA was a mixture of financial and regulatory challenges combined with an increase in financial stability. Regulatory uncertainty such as the possible repeal of the ACA, elimination of the cost-sharing reduction (CSR) payments, and reductions in advertising for the FFM created higher market uncertainty for both consumers and health insurers than would normally have existed under the ACA as written.

During October 2017, the federal government ended the CSR payment program, which required comprehensive health insurers to raise rates higher than they would have been had the CSR payments continued. The combination of higher premium revenue and more accurate pricing information for health insurers led to the beginning of a financial recovery. Comprehensive health insurers reported better financial results during 2017 than they did during the first three years of the full implementation of the ACA, suggesting that health insurers were returning to profitability.

During 2018, the fifth year of the full implementation of the ACA, comprehensive health insurers reported significantly improved financial results. The high losses that were common from 2014 to 2016 were no longer occurring as the large rate increases that were implemented during 2017 and 2018 allowed health insurers to cover the cost of the health care services being provided for their members. The combination of higher premium revenue and more accurate pricing information, particularly in the individual market, has led to a financial recovery. Comprehensive health insurers reported a level of profitability not seen since prior to the full implementation of the ACA.

During 2019, the sixth year of the full implementation of the ACA, premium income stabilized and the financial pattern started in 2018 continued through 2019. The higher premium income helped health insurers cover the cost of health care services that they were paying out for their members. Comprehensive health insurers reported positive financial results for the third year in a row.

During 2020, the seventh year of the full implementation of the ACA, net income increased significantly. This was due to a slight decline in health care spending caused by members delaying or forgoing healthcare treatment due to the COVID-19 pandemic, stable premium income, and a one-time risk corridor payment from the federal government.

During 2021, the eighth year of the full implementation of the ACA, net income declined compared to 2020. Although losses were higher during 2021, premium income remained stable and health insurers were able to cover the costs of their members' health care services. Comprehensive health insurers reported a level of profitability comparable to 2017.

As required by Utah Code § 31A-22-650, the Insurance Department collected data from insurers with a health care preauthorization requirement. This data includes information on the percentage of authorizations for the previous calendar year, not including a claim involving urgent care, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the authorization request. An insurer may not have a preauthorization requirement for emergency health care as described in Utah Code § 31A-22-627. On average, the percentage of health care authorizations processed more than one week after the day on which the insurer received the authorization request was 11.8 percent (see page 15).

As required by Utah Code § 31A-46-301, the Insurance Department collected data from licensed pharmacy benefit managers operating in the State of Utah. This data included the total value of all rebates and administrative fees and the percentage of aggregate rebates that were retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer. Based on these reports, the overall percentage of rebates retained was 5.55 percent (see page 53).

As requested by the Utah Legislature, the Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market. These recommendations are reported in the Appendix (see page 64).

Introduction

For most people, health insurance is the financing mechanism to manage personal health care costs. Health insurance protects against the risk of financial loss that can occur from unexpected accidents and illnesses. It also provides a way for chronic health problems to be treated and managed in ways that many people could not otherwise afford. Because health insurance is so important to the citizens of Utah, it is in the interest of the State to monitor and maintain a stable health insurance industry.

An important purpose of the Insurance Department is to ensure that Utah has an adequate and healthy insurance market. The purpose of this report is to provide an annual evaluation of Utah's commercial health insurance market as required by Utah Code § 31A-2-201.2.

What is Health Insurance?

In general, health insurance transfers the risk of paying for personal health care from an individual to an entity that pools the risk. The individual shares in the management of his or her personal health care risk through the use of deductibles, coinsurance, and the health benefits provided by insurance. Individuals obtain their health benefits from one or more of several sources, such as government sponsored health benefit plans, employer sponsored self-funded health benefit plans, and commercial insurance health benefit plans. The health benefits provided by these plans will range from comprehensive major medical benefits to single disease or accident only benefits.

Government sponsored health benefit plans are government programs that provide health benefits. These programs may be funded entirely by government funds or by a combination of government funds and premiums paid by the covered individuals enrolled in the program. The risk of financial loss is borne by the government. These programs may provide comprehensive major medical health benefits (such as Medicaid and Medicare), limited primary health benefits (such as county health clinics), or limited specialized health benefits.

Employer sponsored self-funded health benefit plans are plans sponsored by an employer to provide health benefits to the employer's employees. These plans may be funded entirely by the employer or by a combination of employer funds and amounts withheld from covered employees' wages. The risk of financial loss is borne by the employer. However, most self-funded plans purchase commercial stop-loss insurance coverage for added protection. These plans usually provide comprehensive major medical health insurance benefits and may provide benefits only to the employee or to the employee and the employee's dependents.

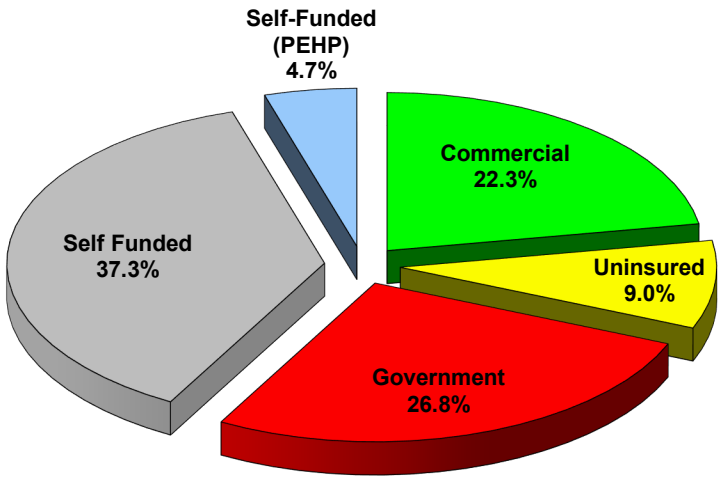
Commercial health insurance plans are plans marketed by an insurance company to provide health insurance benefits to insured persons. These plans are funded by the premiums collected from insured employers and individuals. The risk of financial loss is borne by the insurance company. Commercial insurance benefit plans can be issued as fee-for-service plans, nonprofit health service plans, health maintenance organizations, and limited health plans. The health insurance benefits provided will vary from comprehensive major medical health insurance to specified limited health insurance benefits such as dental, vision, or specified disease.

Each of these three sources of health benefits is regulated by a different set of laws and government programs. Government sponsored health benefit plans are regulated by Federal regulatory agencies like the Centers for Medicare and Medicaid Services (CMS). Employer sponsored self-funded health benefit plans are regulated for the most part under the Federal ERISA statute through the U.S. Department of Labor (DOL), the Centers for Medicare and Medicaid Services (CMS), and the Internal Revenue Service (IRS). Commercial health insurance is governed by state and federal law and is regulated by state insurance departments. This report focuses on the commercial health insurance market regulated by the Insurance Department.

Estimate of Health Insurance Coverage in Utah

As mentioned previously, health insurance comes from three sources: government, employers, and commercial insurers. The Insurance Department has attempted to estimate how much of the state is insured by each source of health insurance. The estimate is for comprehensive health insurance coverage only (also known as major medical). A general overview of the department's estimate is shown below in Figure 1 (see Table 1 for details).

Figure 1. Estimate of Health Insurance Coverage for 2021



Data Sources: Centers for Medicare and Medicaid Services, Deseret Mutual Benefit Administrators, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the U.S. Census Bureau.

Note: The estimate of the 2021 employer sponsored self-funded membership is based on limited data from commercial insurers and employers. It is not a complete count of the self-funded membership in Utah and should be used with caution. Estimates may not total exactly due to rounding and differences in methodology.

Caution should be used interpreting these results, however, as multiple data sources with different methods were required to create this estimate. For example, membership data for government sponsored health benefit plans was obtained from the Utah Department of Health and the Centers for Medicare and Medicaid Services (CMS). Membership data for commercial health insurance was obtained from the Utah Accident & Health Survey, a survey conducted annually by the Insurance Department. The estimate for the uninsured was obtained from the U.S. Census Bureau.

Membership for employer sponsored self-funded health benefit plans was estimated using the best information available to the Insurance Department. Currently, there is no single source of self-funded membership data for Utah. As a result, a "best guess" estimate was created using a combination of membership data obtained from government sponsored plans, large self-funded employers, commercial health insurers who administer self-funded health benefit plans. The result is imperfect, but it does provide an estimate of the self-funded population.

Given these limitations, the Insurance Department estimates that nearly 27 percent of Utah residents were covered by government plans, about 42 percent were covered by self-funded plans, and over 22 percent were covered by commercial health insurance, and about 9 percent were uninsured (see Table 1).

Table 1. Estimate of Health Insurance Coverage for 2021

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans	**893,827**	**26.8%**
Medicare	428,379	12.8%
Medicaid	455,927	13.7%
Children's Health Insurance Program (CHIP)	9,521	0.3%
Employer Sponsored Self-Funded Plans	**1,400,702**	**42.0%**
Plans Administered by Commercial Insurers	780,245	23.4%
Public Employee Health Program (PEHP)	155,914	4.7%
Federal Employee Health Benefit Plan (FEHBP)	122,038	3.7%
Other Known Self-Funded Plans	62,209	1.9%
Other Self-Funded Plans (Estimated)	280,296	8.4%
Commercial Health Insurance Plans	**744,446**	**22.3%**
Group	491,102	14.7%
Individual	253,344	7.6%
Uninsured Estimate	**299,000**	**9.0%**
Total	**3,337,975**	**100.0%**

Data Sources: Centers for Medicare and Medicaid Services, Deseret Mutual Benefit Administrators, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the U.S. Census Bureau.

Note: The estimate of the 2021 employer sponsored self-funded membership is based on limited data from commercial insurers and employers. It is not a complete count of the self-funded membership in Utah and should be used with caution. Estimates may not total exactly due to rounding and differences in methodology.

Utah's Commercial Health Insurance Market

Commercial insurers are companies in the business of managing risk. They accept the risk of loss to individuals or organizations in exchange for a premium. In doing so, the risk of loss is shared (or pooled) so that any one individual does not bear all the risk of loss.

Insurance companies report financial data to the Insurance Department and the National Association of Insurance Commissioners (NAIC) on the health insurance business written in Utah. Health insurance premium data include premiums from individual and group policyholders and government sponsored programs such as Medicare and Medicaid. The premium reported does not include fees paid to insurers for the administration of self-funded health benefit plans.

One measure of a commercial insurer's financial health is the ratio of incurred losses to premiums earned. This ratio is called a loss ratio. A ratio of less than 100 indicates that an insurance company received more premium income than it paid out in claims. A ratio of more than 100 indicates that a company paid more in claims than it received in premium income. While the benchmarks vary depending on the type of insurance, commercial health insurers generally try to maintain a loss ratio of less than 85 (85 cents of losses for every dollar of premium). If the loss ratio increases much beyond 85, an insurer may have more expenses than income and suffer a financial loss. Loss ratios calculated in this report use the traditional loss ratio methodology rather than the NAIC medical loss ratio methodology that adjusts for taxes and fees, as these ratios do not apply to all types of commercial health insurance.

Commercial Health Insurance Market Overview

Among commercial health insurers, there is a broad universe of "health insurance" products. Commercial health insurance may include comprehensive health insurance, as well as insurance products that cover a specialized category such as long-term care, dental, vision, disability, accident, specified disease, or as a supplement to other kinds of health benefit plans.

There were 1,451 commercial fraternal, life, health, and property and casualty insurers licensed with the Insurance Department at the end of 2021. Of these, three hundred and thirty-eight commercial insurers reported commercial health insurance business in Utah on their 2021 annual financial statements. These insurers represent all of the commercial health insurance sold in Utah. Each commercial insurer reported direct premiums and losses in Utah, as well as total revenue and net income for their company.

Table 2 summarizes some of the characteristics of Utah's commercial health insurance market that can be obtained from annual financial statements. As a group, Utah's commercial health insurers had a loss ratio of 84 and a net income of 5.3 percent (see Table 2). Although company loss ratios for accident & health business in Utah do provide an accurate view of commercial health insurers' Utah operations, net income (at the company level) does not. In this case, net income is not a good measure of the financial health of Utah's market as less than one percent of the total revenues reported were in Utah. A more accurate view is obtained by looking at an insurer's state of domicile.

Domestic insurers have a home office in Utah. Foreign insurers have a home office in another state. About 76 percent of Utah's commercial health insurance market is domestic. These 26 domestic insurers are much more representative of the Utah market as about 65 percent of their total revenue comes from Utah business. Thus, their loss ratios and net income are a much more accurate measure of the Utah market. As a group, domestic insurers had a loss ratio of 87 and a net income of 3.3 percent. Utah's commercial health insurance market is highly concentrated among eleven domestic commercial health insurers, which account for about 74 percent of the commercial health insurance market. These eleven commercial health insurers represent about 98 percent of the domestic market. They had a loss ratio of 87 and a net income of 4.0 percent. The remaining two percent of the domestic market consists of life insurers and limited health plans.

There are 312 foreign insurers in Utah's commercial health insurance market, most of which are life insurers. These foreign insurers account for about 24 percent of Utah's market. Foreign insurers had a loss ratio of 75 for Utah business. Net income was 5.3 percent, but a negligible amount of total revenue (less than 1 percent) was from Utah business and is, therefore, not representative of Utah (see Table 2). Overall, foreign insurers have a small presence in Utah's health insurance market.

Table 2. Total Commercial Health Insurance Market by Insurer Type for 2021

		Utah Operations			National Operations	
Insurer Type	**Company Count**	**Direct Earned Premium**	**Market Share**	**Loss Ratio**	**Total Revenue**	**Net Income (% Rev)**
Domestic Insurers						
Health	11	$6,536,779,761	74.09%	87.43	$7,539,198,548	4.0%
Life	11	$119,335,864	1.35%	89.02	$2,710,743,956	1.3%
Limited Health Plan	4	$6,668,361	0.08%	50.62	$6,889,619	6.6%
Total Domestic	**26**	**$6,662,783,986**	**75.52%**	**87.43**	**$10,256,832,123**	**3.3%**
Foreign Insurers						
Fraternal	11	$1,330,462	0.02%	167.96	$15,174,064,477	17.9%
Life	259	$2,098,279,076	23.78%	75.28	$841,476,833,811	4.6%
Property & Casualty	42	$59,785,665	0.68%	52.21	$134,975,848,108	8.2%
Total Foreign	**312**	**$2,159,395,203**	**24.48%**	**74.70**	**$991,626,746,396**	**5.3%**
Utah Insurers						
Fraternal	11	$1,330,462	0.02%	167.96	$15,174,064,477	17.9%
Health	11	$6,536,779,761	74.09%	87.43	$7,539,198,548	4.0%
Life	270	$2,217,614,940	25.14%	76.02	$844,187,577,767	4.6%
Limited Health Plan	4	$6,668,361	0.08%	50.62	$6,889,619	6.6%
Property & Casualty	42	$59,785,665	0.68%	52.21	$134,975,848,108	8.2%
Total Utah	**338**	**$8,822,179,189**	**100.00%**	**84.31**	**$1,001,883,578,519**	**5.3%**

Data Source: NAIC Financial Database

Note: The total direct earned premium and total revenue reported here is based on the annual financial statement data submitted by commercial insurers to the National Association of Insurance Commissioners (NAIC). Estimates may not total exactly due to rounding.

Commercial Health Insurance Market by Policy Type

Financial statement data is designed to measure the financial solvency of commercial insurers. As such, it is not designed to provide detailed information on a particular type of insurance. To compensate for this, Utah's commercial health insurers are required to participate in the Utah Accident & Health Survey. This survey collects data about the various types of health insurance in greater detail than the annual statement. Data was collected from 338 commercial health insurers who reported accident & health premium in Utah for 2021.

The top four policy types by market share were comprehensive health insurance (38 percent), Medicare Advantage products (25 percent), Medicaid/CHIP (12 percent), and Federal Employee Health Benefit Plan (FEHBP) (8 percent) (see Table 3). The results of the survey differ slightly from the total accident & health reported on the 2021 annual statement, however, the difference is small. The net difference in the total reported direct earned premium is less than 0.1 percent.

Table 3. Total Commercial Health Insurance Market by Policy Type for 2021

Policy Type	Company Count [a]	Member Count [b]	Direct Earned Premium	Market Share	Loss Ratio
Comprehensive	29	744,446	$3,392,957,126	38.46%	86.66
Hospital-Medical-Surgical	32	16,990	$6,004,172	0.07%	39.47
Short-Term Limited Duration	7	7,588	$12,606,230	0.14%	99.23
Medicare Supplement	110	86,290	$195,539,986	2.22%	78.04
Medicare Advantage	17	183,391	$2,189,484,593	24.82%	85.66
Medicare Drug Plan	12	111,274	$63,387,438	0.72%	76.38
Dental Only	78	970,219	$318,472,641	3.61%	76.28
Vision Only	46	1,026,953	$58,854,491	0.67%	58.34
FEHBP	7	122,038	$686,286,479	7.78%	93.36
Medicaid/CHIP	3	296,955	$1,092,419,086	12.38%	85.51
Stop-Loss	43	691,963	$350,273,879	3.97%	82.96
Disability Income	126	761,728	$234,507,135	2.66%	67.86
Long-Term Care	66	31,033	$41,287,828	0.47%	84.04
Credit A&H	21	126,845	$6,398,861	0.07%	27.82
All Other A&H	196	-	$174,538,475	1.98%	39.46
Total Accident & Health	**338**	**-**	**$8,823,018,420**	**100.00%**	**84.31**

Data Source: Utah Accident & Health Survey

Note: The Federal Employee Health Benefit Plans (FEHBP), Medicare, and Medicaid business reported here may include some health benefit plans that are not fully insured as NAIC accounting rules allow certain types of administrative business to be reported on the state page of the annual statement. These categories are included here to ensure that the accident & health business being reported in the Utah Accident & Health Survey is consistent with the accident & health business being reported on the Utah state page of the NAIC annual statement. Estimates may not total exactly due to rounding.

[a] Company count column does not add up to the total because an insurer may have more than one policy type.

[b] A total is not reported for the column "Member Count" and for "Other." A sum total of the membership counts of all types of health insurance would overestimate the actual number of persons covered by commercial health insurance due to uncontrolled double counting of members.

Consumer Complaints Against Commercial Health Insurance Companies

A key function of the Insurance Department is to assist consumers with questions and concerns that they have about commercial health insurance coverage. The primary agency within the Insurance Department that assists consumers with health insurance issues is the Office of Consumer Health Assistance (OCHA) within the Health and Life Division.

OCHA seeks to provide a variety of needed services to health care consumers and policymakers, including (but not limited to):

- Assisting consumers in understanding their contractual rights and responsibilities, statutory protections, and available remedies under their health plan
- Providing health care consumer education (producing, collecting, disseminating educational materials; conducting outreach programs and other educational activities)
- Investigating and resolving complaints
- Assistance to those having difficulty accessing their health care plan because of language, disability, age, or ethnicity
- Providing information and referral to these persons as well as help with initiating the grievance process
- Analyzing and monitoring federal and state regulations that apply to health care consumers

Consumers contact OCHA for a variety of reasons. These contacts range from simple questions about how to obtain health insurance coverage to complaints against a particular health insurance company. OCHA engages in more than 6,000 telephone contacts with consumers on average each year. In addition to telephone contacts, OCHA staff also respond to a wide variety of health and life cases based on the needs of a consumer. Total cases include general inquiries, complaints for health and life, independent reviews, investigations, and complaints against self-funded plans and policies issued in other states where the Insurance Department does not have jurisdiction. The COVID-19 pandemic had an effect on the number of telephone contacts and total cases during 2020 (see Table 4). Consumers delayed or reduced elective healthcare treatment in order to comply with social distancing guidelines and to preserve hospital capacity. Data for 2021 shows an increase in consumer activity compared to 2020.

Table 4. Number of Consumer Telephone Contacts Handled by OCHA Staff: 2012 - 2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Telephone (in/out)	5,151	5,563	4,202	4,369	6,892	5,685	8,349	9,691	7,274	7,357
Total Cases [a]	-	-	-	-	-	-	1,115	1,043	846	1,013

Data Source: Utah Insurance Department

Note: Due to a software limitation in the Utah Insurance Department's phone system during 2020 and 2021, this data may not include all of the phone calls received by an employee's direct line.

[a] Total cases are reported for 2018-2021. All data is current as of Dec. 31 of the report year.

When a consumer contact involves a possible violation by a commercial health insurance company of Utah insurance regulations or federal regulations the Insurance Department is mandated to regulate, OCHA encourages consumers to file a written complaint. Once a written complaint is received, OCHA conducts an investigation and seeks to resolve the consumer complaint. OCHA tracks all written complaints made against commercial health insurers. These complaints are classified into two types: confirmed and unconfirmed.

Confirmed Complaints. Confirmed complaints are those where the Insurance Department rules in favor of the consumer making the complaint. The Insurance Department determines that the complaint is warranted under the law and resolves the complaint by requiring the commercial health insurer to act to correct the problem.

Unconfirmed Complaints. Unconfirmed complaints are those where the Insurance Department rules in favor of the commercial insurer as the insurer was found to be acting within the bounds of the law or that the Insurance Department was unable to make a ruling, either because there are unresolved questions about the facts of the case or because the department does not have the legal authority to do so. In these situations, the Insurance Department educates consumers as to their rights under the law and how health insurance contracts work.

As shown in Table 5, the total number of complaints increased from 2012 to 2016, declined from 2017 to 2020, and then increased during 2021. The number of confirmed complaints increased significantly from 2012 to 2016, declined from 2017 to 2020, and then increased during 2021. The number of unconfirmed complaints remained stable from 2012 to 2014, followed by a significant increase from 2015 to 2017, declined from 2018 to 2020, and then increased during 2021 (see Table 5).

Table 5. Complaints Filed with OCHA by Type: 2012 - 2021

	Total		Confirmed		Unconfirmed	
Year	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
2012	161	100.0%	53	32.9%	108	67.1%
2013	180	100.0%	80	44.4%	100	55.6%
2014	201	100.0%	101	50.2%	100	49.8%
2015	280	100.0%	136	48.6%	144	51.4%
2016	344	100.0%	140	40.7%	204	59.3%
2017	324	100.0%	85	26.2%	239	73.8%
2018	265	100.0%	46	17.4%	219	82.6%
2019	215	100.0%	28	13.0%	187	87.0%
2020	146	100.0%	12	8.2%	134	91.8%
2021	177	100.0%	22	12.4%	155	87.6%
Average	**229**	**100.0%**	**70**	**30.6%**	**159**	**69.4%**

Data Source: Utah Insurance Department

Note: Estimates may not total exactly due to rounding.

The OCHA staff and the Utah health insurance industry work diligently to resolve consumer concerns before they rise to the level of a formal written complaint. Consumers continue to contact the Insurance Department in significant numbers (see Table 4). The number of consumer complaints increased during the implementation of the ACA, but has started to decline towards pre-ACA levels. In addition, the COVID-19 pandemic has had an effect on the number of complaints and independent reviews processed by OCHA staff. Consumers delayed or reduced elective healthcare treatment during the COVID-19 pandemic in order to comply with social distancing guidelines and to preserve hospital capacity. During 2021, the number of complaints increased by about 21 percent.

Another important trend over the last seven years has been an increase in the number of complaints related to the issue of balance billing, where a health care provider bills the patient for the difference between the provider's charge and the amount paid by health insurance. Balance billing complaints accounted for about 10 percent of all consumer complaints from 2015 to 2017, about 16 percent during 2018, about 8 percent during 2019, about 10 percent during 2020, and about 6 percent during 2021. In response to this pattern in Utah and other states, the federal government passed the No Surprises Act (No Surprises Act, 2021). This new law addresses the issue of balance billing and provides consumer protections for surprise medical billing. This federal law applies to individual and group health benefit plans and took effect on January 1, 2022.

In addition to tracking the number of written complaints and how they are resolved, the Insurance Department also tracks the reason for the complaint. As shown in Table 6, on average, about 67 percent of all consumer complaints are due to claim handling issues, while policyholder services and marketing & sales issues account for the remainder (see Table 6).

Table 6. Complaints Filed with OCHA by Reason: 2012 - 2021

	Total		Claim Handling		Policyholder Services		Marketing & Sales	
Year	Count [a]	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
2012	162	100.0%	111	68.5%	26	16.0%	25	15.4%
2013	180	100.0%	132	73.3%	39	21.7%	9	5.0%
2014	201	100.0%	118	58.7%	77	38.3%	6	3.0%
2015	280	100.0%	174	62.1%	89	31.8%	17	6.1%
2016	344	100.0%	200	58.1%	130	37.8%	14	4.1%
2017	334	100.0%	239	71.6%	90	26.9%	5	1.5%
2018	279	100.0%	196	70.3%	75	26.9%	8	2.9%
2019	229	100.0%	165	72.1%	50	21.8%	14	6.1%
2020	148	100.0%	121	81.8%	27	18.2%	0	0.0%
2021	189	100.0%	122	64.6%	53	28.0%	14	7.4%
Average	**235**	**100.0%**	**158**	**67.2%**	**66**	**28.1%**	**11**	**4.7%**

Data Source: Utah Insurance Department

Note: Policyholder Services includes complaints regarding policyholder services and underwriting practices. Estimates may not total exactly due to rounding.

[a] A complaint may have more than one reason code, so totals may be higher than the actual number of complaints.

Complaint Ratios. Another measure of complaint activity is the complaint ratio. A complaint ratio is a measure of how many consumer complaints were received compared to the amount of business a commercial health insurer did in the state. Table 7 reports the average complaint ratios for the commercial health insurance market from 2012 to 2021 (see Table 7). Each complaint ratio reports the number of complaints per $1,000,000 in total direct earned premium. For example, a ratio of 1 means the insurer had 1 complaint for every $1,000,000 in premium.

Table 7. Complaint Ratios for the Commercial Health Insurance Market: 2012 - 2021

		Total		Confirmed		Unconfirmed	
Year	Direct Earned Premium	Count	Ratio	Count	Ratio	Count	Ratio
2012	$4,529,016,267	161	0.04	53	0.01	108	0.02
2013	$5,052,971,179	180	0.04	80	0.02	100	0.02
2014	$5,467,438,932	201	0.04	101	0.02	100	0.02
2015	$5,705,636,933	280	0.05	136	0.02	144	0.03
2016	$6,215,575,220	344	0.06	140	0.02	204	0.03
2017	$6,577,788,210	324	0.05	85	0.01	239	0.04
2018	$7,134,644,985	265	0.04	46	0.01	219	0.03
2019	$7,421,241,744	215	0.03	28	< 0.01	187	0.03
2020	$8,307,738,287	146	0.02	12	< 0.01	134	0.02
2021	$8,822,179,189	177	0.02	22	< 0.01	155	0.02
Average	**$6,523,423,095**	**229**	**0.04**	**70**	**0.01**	**159**	**0.03**

Data Sources: NAIC Financial Database and the Utah Insurance Department

Note: Estimates may not total exactly due to rounding.

As Table 7 shows, the average complaint ratio for the commercial market is about 0.04 for all complaints, about 0.01 for confirmed complaints, and about 0.03 for unconfirmed complaints. Using this average as a benchmark, the complaint ratios for 2021 are lower than the ten-year average.

Table 8 reports individual complaint ratios for commercial health insurance companies during 2021. The averages in Table 7 can be used to give perspective to these individual ratios. For example, a commercial health insurer with a total complaint ratio of greater than 0.04 has a higher than average number of complaints, while a ratio of less than 0.04 means a lower than average number of complaints. It is also important to remember that a complaint ratio is only one aspect of evaluating a commercial health insurance company (see Table 8).

Table 8. Commercial Health Insurance Companies with Consumer Complaints during 2021

Company Name	Direct Earned Premium	Market Share	Total [a] Count	Total [a] Ratio	Confirmed Count	Confirmed Ratio	Unconfirmed Count	Unconfirmed Ratio
Aetna Life Ins Co	$206,409,884	2.34%	1	< 0.01	1	< 0.01	-	-
American Family Life Assur Co	$16,990,825	0.19%	1	0.06	-	-	1	0.06
American National Life Ins Co Of TX	$12,605,561	0.14%	1	0.08	-	-	1	0.08
Ameritas Life Ins Corp	$49,772,845	0.56%	3	0.06	-	-	3	0.06
Bankers Fidelity Assurance Co	$1,040,999	0.01%	1	0.96	-	-	1	0.96
Cigna Health& Life Ins Co	$260,290,824	2.95%	5	0.02	-	-	5	0.02
Delta Dental Ins Co	$14,360,820	0.16%	1	0.07	-	-	1	0.07
Educators Health Plans Life Acc & Health	$63,862,715	0.72%	1	0.02	-	-	1	0.02
Educators Mutual Ins Association	$34,175,835	0.39%	1	0.03	-	-	1	0.03
Guardian Life Ins Co Of America	$17,756,146	0.20%	1	0.06	-	-	1	0.06
Hartford Life & Accident Ins Co	$48,319,260	0.55%	1	0.02	1	0.02	-	-
Humana Ins Co	$140,418,934	1.59%	5	0.04	3	0.02	2	0.01
Humanadental Ins Co	$5,810,397	0.07%	1	0.17	-	-	1	0.17
Life Ins Co Of N America	$24,634,657	0.28%	1	0.04	-	-	1	0.04
LifeMap Assurance Co	$12,201,122	0.14%	1	0.08	-	-	1	0.08
Metropolitan Life Ins Co	$64,052,355	0.73%	8	0.12	-	-	8	0.12
Molina Healthcare of UT Inc	$544,080,486	6.17%	22	0.04	1	< 0.01	21	0.04
National Guardian Life Ins Co	$4,456,938	0.05%	1	0.22	-	-	1	0.22
National Foundation Life Ins Co	$22,723,976	0.26%	3	0.13	1	0.04	2	0.09
Philadelphia American Life Ins Co	$2,599,128	0.03%	1	0.38	-	-	1	0.38
Regence BCBS of UT	$1,177,551,793	13.35%	17	0.01	-	-	17	0.01
SelectHealth Inc	$3,200,341,588	36.28%	46	0.01	10	< 0.01	36	0.01
SILAC Ins Co	$3,554,659	0.04%	3	0.84	-	-	3	0.84
UnitedHealthcare Ins Co	$350,412,690	3.97%	35	0.10	3	0.01	32	0.09
University of UT Health Ins Plans	$129,128,390	1.46%	7	0.05	1	0.01	6	0.05
Unum Ins Co	$1,145,974	0.01%	1	0.87	-	-	1	0.87
Top 26 companies with complaints [b]	**$6,408,698,801**	**72.64%**	**169**	**0.03**	**21**	**< 0.01**	**148**	**0.02**
Remaining 7 companies with complaints [c]	$3,124,425	0.04%	8	2.56	1	0.32	7	2.24
Companies without complaints [d]	$2,410,355,963	27.32%	-	-	-	-	-	-
Total Commercial Market	**$8,822,179,189**	**100.00%**	**177**	**0.02**	**22**	**< 0.01**	**155**	**0.02**

Data Sources: NAIC Financial Database and the Utah Insurance Department

Note: Estimates may not total exactly due to rounding.

[a] Total complaints includes Confirmed and Unconfirmed.
[b] Describes all companies with complaints that had at least $1,000,000 in total direct earned premium.
[c] Separate complaint ratios were not calculated for companies with less than $1,000,000 in total direct earned premium because it produces distorted ratios that cannot be directly compared to other companies.
[d] There were 305 companies without complaints.

Independent Reviews by an Independent Review Organization

In addition to consumer complaints, the Insurance Department receives and processes requests from consumers for an independent review of their denied claims by an Independent Review Organization (IRO). An independent review may be filed after the consumer has exhausted the standard claim appeals process with their commercial health insurer.

When the Insurance Department receives a request for an independent review of a denied claim, it is assigned to an IRO for review. IROs conduct an independent review of certain classes of claims denied by commercial health insurers. Not all denied claims are eligible for an independent review. The independent review primarily focuses on claims where health care services were denied, but were medically necessary or experimental. For example, a claim that was denied because it was not a covered benefit under the consumer's health benefit plan would not be eligible for an independent review, however, a claim that was denied because the insurer determined it was experimental or not medically necessary might be eligible for a review.

The independent review process produces one of three outcomes: not eligible, overturned, or upheld.

Not eligible. The denied claim did not meet the minimum eligibility criteria to be reviewed. Not all denied claims are eligible for independent review. In most cases, a denied claim must involve a question of medical necessity or health care services that are experimental or investigational.

Overturned. The IRO reviewer reverses the decision made by the commercial health insurer and rules in favor of the consumer. The health insurer is asked to cover the health care services in the claim under the terms of the health insurance policy.

Upheld. The IRO reviewer agrees with the original decision made by the commercial health insurer and determines that the insurer acted appropriately. No other appeals are possible.

As shown in Table 9, the Insurance Department receives, on average, about 133 requests for an independent review each year. About 74 percent of these requests are eligible for a review. During 2021, the Insurance Department received 149 requests for an independent review. This is a decrease of about 7 percent compared to the number of requests received during 2020. Of the 149 requests for an independent review received during 2021, nearly 77 percent were eligible for an independent review (see Table 9).

Table 9. Requests for Independent Reviews by Eligibility: 2012 - 2021

	Total		Not Eligible		Eligible	
Year	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
2012	61	100.0%	13	21.3%	48	78.7%
2013	66	100.0%	16	24.2%	50	75.8%
2014	69	100.0%	16	23.2%	53	76.8%
2015	111	100.0%	30	27.0%	81	73.0%
2016	157	100.0%	55	35.0%	102	65.0%
2017	159	100.0%	35	22.0%	124	78.0%
2018	216	100.0%	55	25.5%	161	74.5%
2019	180	100.0%	51	28.3%	129	71.7%
2020	161	100.0%	42	26.1%	119	73.9%
2021	149	100.0%	35	23.5%	114	76.5%
Average	**133**	**100.0%**	**35**	**26.3%**	**98**	**73.7%**

Data Source: Utah Insurance Department

Note: Estimates may not total exactly due to rounding. Data year 2012 includes data from Dec. 2011, the first month Independent Reviews began.

The Insurance Department also tracks the reason for the request for an independent review. As shown in Table 10, about 61 percent of all requests for independent reviews are for medical necessity; with experimental and investigational accounting for about 19 percent and contract denial accounting for about 20 percent (see Table 10).

Table 10. Requests for Independent Reviews by Reason: 2012 - 2021

	Total		Contract Denial		Experimental / Investigational		Medical Necessity	
Year	Count [a]	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
2012	61	100.0%	20	32.8%	13	21.3%	28	45.9%
2013	68	100.0%	18	26.5%	14	20.6%	36	52.9%
2014	69	100.0%	1	1.4%	6	8.7%	62	89.9%
2015	111	100.0%	33	29.7%	32	28.8%	46	41.4%
2016	157	100.0%	27	17.2%	42	26.8%	88	56.1%
2017	159	100.0%	13	8.2%	41	25.8%	105	66.0%
2018	216	100.0%	9	4.2%	37	17.1%	170	78.7%
2019	191	100.0%	28	14.7%	40	20.9%	123	64.4%
2020	228	100.0%	80	35.1%	25	11.0%	123	53.9%
2021	222	100.0%	73	32.9%	35	15.8%	114	51.3%
Average	**148**	**100.0%**	**30**	**20.3%**	**28**	**18.9%**	**90**	**60.8%**

Data Source: Utah Insurance Department

Note: Estimates may not total exactly due to rounding. Data year 2012 includes data from Dec. 2011, the first month Independent Reviews began. Contract denials may include rescissions. Rescissions are rare and not broken out as a separate category.

[a] An independent review may have more than one reason code, so totals may be higher than the actual number of independent reviews.

As mentioned previously, not all requests for an independent review are eligible for an independent review, regardless of the reason for the request. On average, about 74 percent of independent reviews are eligible. During 2021, nearly 77 percent of requests for an independent review were eligible. Out of the requests eligible for an independent review, nearly 45 percent were upheld, while over 55 percent were overturned. On average, about 50 percent of independent reviews are upheld and about 50 percent are overturned (see Table 11).

Table 11. IRO Decisions by Outcome: 2012 - 2021

	Total Eligible		Upheld		Overturned	
Year	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
2012	48	100.0%	30	62.5%	18	37.5%
2013	50	100.0%	38	76.0%	12	24.0%
2014	53	100.0%	30	56.6%	23	43.4%
2015	81	100.0%	50	61.7%	31	38.3%
2016	102	100.0%	52	51.0%	50	49.0%
2017	124	100.0%	55	44.4%	69	55.6%
2018	161	100.0%	72	44.7%	89	55.3%
2019	129	100.0%	61	47.3%	68	52.7%
2020	119	100.0%	55	46.2%	64	53.8%
2021	114	100.0%	51	44.7%	63	55.3%
Average	**98**	**100.0%**	**49**	**50.0%**	**49**	**50.0%**

Data Source: Utah Insurance Department

Note: Estimates may not total exactly due to rounding. Data year 2012 includes data from Dec. 2011, the first month Independent Reviews began.

Health Care Preauthorization Reporting

Utah Code § 31A-22-650 requires an insurer with a health care preauthorization requirement to submit a report to the Insurance Department on or before April 1, 2021, and each year thereafter. Each insurer is required to report the percentage of authorizations for the previous calendar year, not including a claim involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the authorization request. An insurer may not have a preauthorization requirement for emergency health care as described in Utah Code § 31A-22-627.

There were 29 comprehensive health insurers doing business in Utah during 2021. Below is a summary of the information reported to the Insurance Department for the calendar year 2021 (see Table 12). Based on these reports, seventeen companies reported authorizations processed more than one week after the day on which the insurer received the authorization request. The insurer average was 11.8 percent.

Table 12. Health Care Preauthorizations processed after one week during 2021

Company Name	State of Domicile	Percentage Processed After One Week
4 Ever Life Insurance Company	IL	100.0%
Aetna Health of Utah, Inc.	UT	3.4%
Aetna Life Insurance Company	CT	6.0%
All Savers Insurance Company	IN	5.2%
American National Insurance Company	TX	0.0%
American National Life Insurance Company of Texas	TX	0.0%
Angle Insurance Company of Utah dba Angle Health	UT	0.0%
Bridgespan Health Company	UT	0.0%
Cigna Health & Life Insurance Company	CT	12.0%
Educators Health Plans Life, Accident and Health	UT	0.0%
Educators Mutual Insurance Association	UT	3.1%
Equitable Financial Life Insurance Company	NY	0.0%
Freedom Life Insurance Company of America	TX	0.0%
Health Care Service Corporation, a Mutual Legal Re	IL	59.6%
Humana Insurance Company	WI	12.9%
Metropolitan Life Insurance Company	NY	0.0%
Molina Healthcare of Utah, Inc.	UT	31.5%
MotivHealth Insurance Company	UT	23.6%
National Health Insurance Company	TX	30.2%
Prudential Insurance Company of America	NJ	0.0%
Regence BlueCross BlueShield of Utah	UT	4.9%
SelectHealth, Inc.	UT	5.8%
Standard Life and Accident Insurance Company	TX	0.0%
State Farm Mutual Automobile Insurance Company	IL	0.0%
Transamerica Life Insurance Company	IA	0.0%
UnitedHealthcare Insurance Company	CT	6.2%
UnitedHealthcare of Utah, Inc.	UT	10.1%
University of Utah Health Insurance Plans	UT	57.7%
WMI Mutual Insurance Company	UT	9.1%
All Comprehensive Health Insurers	**29**	**11.8%**

Data Source: Utah Adverse Preauthorization Determination Survey

Utah's Comprehensive Health Insurance Market

Comprehensive health insurance makes up approximately 38 percent of the commercial health insurance market in the state of Utah (see Table 3) and affects about 22 percent of Utah residents (see Table 1). It is the only type of major medical health benefit plan directly regulated by the Insurance Department. The following analysis of the comprehensive market examines various aspects of the market including state of domicile, group size, health benefit plan types, and market trends.

Comprehensive Market by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state. Domestic insurers generally have a larger presence in their state of domicile than foreign insurers. Their local status may assist them in negotiating more favorable provider contracts and creating larger provider networks than foreign insurers.

Approximately 85 percent of the comprehensive health insurance market is served by domestic insurers and is highly concentrated among twelve insurers. Seventeen foreign insurers represent the remaining market share. Premiums in Utah were higher for foreign insurers than domestic with $409 per member per month for foreign and $385 per member per month for domestic. Loss ratios were higher for domestic insurers (see Table 13).

Table 13. Total Comprehensive Market by Domicile for 2021

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [a]
Domestic	12	637,140	$2,883,208,706	84.98%	87.69	$385
Foreign	17	107,306	$509,748,420	15.02%	80.84	$409
Total	**29**	**744,446**	**$3,392,957,126**	**100.00%**	**86.66**	**$388**

Data Source: Utah Accident & Health Survey

[a] Direct earned premium per member per month

Comprehensive Market by Group Size

Comprehensive health insurance plans are sold either as an individual policy or a group policy. Individual policies are sold directly to individual consumers. In contrast, group policies are sold as a single contract to a group of individuals, such as a group of employees. Groups with 1 to 50 eligible employees are classified as small employer groups. Groups with 51 or more eligible employees are classified as large employer groups.

Prior to the passage of the Patient Protection and Affordable Care Act (ACA), individual and small group policy rates were primarily set on the health status of the individual or the small employer group as required by state law. There were no federal regulations limiting how health insurers set their rates. With the enactment of the ACA, individual, small group, and large group policies are now all underwritten without taking individual health status into account, a practice also called community rating. Under community rating, rates are set so that the insurance risk is

spread over the entire community of insured members and individuals pay similar rates regardless of health status.

Under the ACA, rates are set by community rating, without regard to health status or gender. The only factors that may be used in setting rates are the number of individuals or family members enrolled in the health benefit plan, geographic area (some geographic areas have higher medical costs than others), age (older adults have higher health care costs than younger adults, but the top rating tier cannot be more than the 3 times the bottom tier), and tobacco use (rates for tobacco users cannot be more than 1.5 times the rate of non-tobacco users). These changes mean that traditional rating factors such as health status and gender are no longer used. These changes have the most impact on the individual market, where rates were primarily based on the health status of an individual.

In 2021, large group policies reported a higher premium per member per month ($409) than individual policies ($388) or small group policies ($347). Loss ratios were higher for individual and small group policies than for large group policies (see Table 14). Individual policies purchased through the FFM may also receive premium subsidies through the Advance Premium Tax Credit (APTC). About 92 percent of the individual policies sold through the FFM received an APTC. On average, the APTC accounted for about 84 percent of the total monthly premium (Centers for Medicare and Medicaid Services, 2022a).

Table 14. Total Comprehensive Market by Group Size for 2021

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Total Individual	15	253,344	$1,136,384,901	33.49%	89.54	$388
Small Group (1-50)	8	161,722	$662,408,226	19.52%	90.02	$347
Large Group (51+)	21	329,380	$1,594,163,999	46.98%	83.22	$409
Total Group	21	491,102	$2,256,572,225	66.51%	85.21	$389
Total Comprehensive	**29**	**744,446**	**$3,392,957,126**	**100.00%**	**86.66**	**$388**

Data Source: Utah Accident & Health Survey

[a] Company count column does not add up to the total because an insurer may have more than one plan type.
[b] Direct earned premium per member per month

Prior to 2016, comprehensive health insurers did not have enough information to adequately price their products and did not receive the additional payments from the federal risk corridor program as expected. Rating for 2016 was the first year that companies had a full year's claim experience to work with, but there was still significant market uncertainty that made it difficult to price their products and premiums remained insufficient to cover their losses. During 2017, comprehensive health insurers had more accurate pricing information to work with, and this, combined with higher rates that more precisely represented their actual risk experience, resulted in improved loss ratios in the individual market. In October 2017, the federal government eliminated the cost-sharing reduction (CSR) payment program, which required health insurers to raise rates higher than they would have been. During 2018, comprehensive health insurers raised rates in the individual market by approximately 39.9 percent (Utah Insurance Department, 2017), which increased individual premium per member per month by about 45 percent. The impact of the rate increase for an FFM individual plan was significantly

offset due to the APTC funded by the federal government (Centers for Medicare and Medicaid Services, 2018). In contrast, group premium per member per month only increased by 4 percent. During 2019, comprehensive health insurers maintained the premium increases set in 2018 and comprehensive premium per member per month stabilized, increasing by 1.1 percent. During 2020, comprehensive health insurance premium per member per month remained stable, only increasing by 0.8 percent. During 2021, comprehensive health insurance premium continued to remain stable, increasing slightly by 0.5 percent.

Comprehensive Market by Plan Types

In this report, comprehensive health insurance plans are classified into five major plan types: Fee for Service (FFS), Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), and Health Maintenance Organization with Point of Service features (HMO with POS). These plan types differ in the amount of managed care used to maintain quality and manage the cost of health care services. The term "managed care" refers to the methods many third-party payers use to ensure quality care (such as disease management programs) and to reduce utilization and cost of health care services (such as pharmacy benefit managers and medical review boards). HMO plans generally have the most management of care; whereas FFS plans generally have the least.

A Fee for Service (FFS) plan refers to a traditional indemnity plan. Under a FFS plan, members can use any health care provider they choose (as long as the services are a covered benefit on the insurance contract). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges).

A Preferred Provider Organization (PPO) plan refers to a health plan that offers a network of "preferred" providers that have contracted to provide health care services for a reduced fee. Members have financial incentives to use this network of preferred providers, as costs for health care services are typically lower. Members are also free to use providers outside of the network, but services may be denied, or be reimbursed at a lower rate. Regardless, members must pay a larger portion of the cost for health care services when obtaining services from health care providers outside of the network. PPO plans usually include deductibles, co-pays, or coinsurance.

An Exclusive Provider Organization (EPO) plan refers to a health plan that is similar to a PPO in that it offers a network of "preferred" providers that have contracted to provide health care services for a reduced fee. However, unlike a PPO, members may not use providers outside of the network providers and must only use network providers exclusively. EPO plans are similar to HMO plans in that services are usually limited to an exclusive set of network providers, except in the case of an emergency.

A Health Maintenance Organization (HMO) plan refers to a health insurance plan that provides services through a network of health care providers that have negotiated a fee schedule with the HMO. Members enrolled in the plan generally pay a deductible and fixed co-pay for health care visits and drugs. Services are usually not available outside the provider network, except for emergencies.

A Health Maintenance Organization with Point of Service features (HMO with POS) plan is a plan type offered by a licensed HMO. An HMO with POS refers to an HMO plan that gives members the option to use providers who are outside of the HMO network, but at a lower reimbursement rate resulting in members bearing a much larger portion of the cost for health care services in addition to the fixed co-pay and deductibles.

HMO, HMO with POS, PPO, and EPO plans are considered managed care plans. FFS plans typically do not involve any form of managed care. About 97 percent of Utah's comprehensive health insurance market involves some type of managed care; with approximately 68 percent of the comprehensive health market in an HMO or HMO with POS. About 3 percent of the market had a FFS plan (see Table 15).

Table 15. Total Comprehensive Market by Plan Type for 2021

Plan Type	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Fee for Service	13	19,912	$98,913,587	2.92%	80.91	$397
Preferred Provider Organization	17	170,891	$836,141,667	24.64%	81.52	$413
Exclusive Provider Organization	4	25,226	$153,140,264	4.51%	108.98	$500
Health Maintenance Organization	5	347,315	$1,501,841,932	44.26%	85.54	$371
HMO with Point of Service features [c]	2	181,102	$802,919,676	23.66%	90.57	$381
Total	**29**	**744,446**	**$3,392,957,126**	**100.00%**	**86.66**	**$388**

Data Source: Utah Accident & Health Survey

[a] Company count column does not add up to total because an insurer may have more than one plan type.
[b] Direct earned premium per member per month
[c] SelectHealth, Inc., an HMO, provides Point of Service benefits in conjunction with its affiliated indemnity company SelectHealth Benefit Assurance, Inc.

Premium per member per month was higher for EPO plans compared to the other plan types, while HMO plans were the lowest among traditional insurance products. Caution should be used in drawing conclusions from this data, however. This comparison does not control for differences in plan structure, covered benefits, health status, or demographics. For example, one reason some plans have lower premiums than other plans may be a higher deductible and fewer benefits. When a member accepts a higher deductible, the insurer pays for fewer health care services and the member is responsible for a larger portion of their health care expenses. Thus, the insurer bears less financial risk, which is reflected in a lower premium. Another cost control measure used by insurers is the breadth of the provider network. Some plans have very narrow networks, limiting the number of providers a member may use to obtain covered services. The insurer utilizes narrow networks to negotiate with providers to drive more members to a small provider community. These narrow network plans result in lower negotiated provider reimbursements and lower member premiums.

Comprehensive Market by Regulatory Type

As part of the ongoing health care reform efforts, the federal government has created specialized plans that must conform to certain regulations. Requiring compliance to specific statutes is a tool legislatures use to encourage commercial health insurers to provide new insurance products that may meet the needs of specific segments of the market or may provide coverage for people who would not purchase coverage under normal market conditions. Tables 16-18 describe some of the regulatory types that have been created as a result of either state or federal legislation and for which comprehensive health insurers have reported enrollment in Utah.

ACA Compliant Plans vs Non-ACA Compliant Plans. ACA compliant plans are comprehensive health insurance plans that are in full compliance with the federal regulations that have been established for health benefit plans under the Patient Protection and Affordable Care Act (ACA). Non-ACA compliant plans are comprehensive health insurance plans that have qualified for some type of exemption from part of the ACA regulations, termed either grandfathered plans or transitional plans. The majority (over 94 percent) of the comprehensive market were enrolled in ACA compliant plans (see Table 16), with about 94 percent of the large and small group markets and about 95 percent of the individual market enrolled in ACA compliant plans.

Off-Exchange Plans. In addition to ACA compliance, plans can be further divided into "Off-Exchange" or "On-Exchange" plans. An Off-Exchange plan refers to health benefit plans that are sold outside of the state or federal exchanges. In other words, they are sold directly to individuals and employer groups by the commercial health insurer independent of a health exchange. On-Exchange plans refer to health benefit plans that are sold on the Federally Facilitated Marketplace (FFM). All small and large group health benefit plans are Off-Exchange plans. Most (70 percent) of the comprehensive market were enrolled in Off-Exchange plans. The higher percentage of Off-Exchange plans is due to employer groups not having an exchange option. Most (87 percent) of the individual market were enrolled in the FFM. Off-Exchange membership was enrolled in both ACA compliant plans (92 percent) and Non-ACA complaint plans (8 percent).

Federally Facilitated Marketplace (FFM). The Federally Facilitated Marketplace (FFM) is Utah's health exchange for individuals. Policies sold through the FFM are rated using community rating and may be eligible for federal subsidies and income support for purchasing insurance. In 2021, there were 219,441 members (about 29.5 percent of the market) and 6 comprehensive health insurers participating in the FFM during 2021 (see Table 16). All of the policies sold through the FFM are ACA compliant plans.

Table 16. Total Comprehensive Market by ACA Market Segment for 2021

Market Segment by Group Size	Company Count [a]	Member Count	Percent of Members
Individual	**15**	**253,344**	**34.0%**
Non-ACA Compliant			
Off-Exchange	11	13,093	1.8%
ACA Compliant			
Off-Exchange	4	20,810	2.8%
Federally Facilitated Marketplace	6	219,441	29.5%
Small Group	**8**	**161,722**	**21.7%**
Non-ACA Compliant			
Off-Exchange	5	19,328	2.6%
ACA Compliant			
Off-Exchange	7	142,394	19.1%
Large Group	**21**	**329,380**	**44.2%**
Non-ACA Compliant			
Off-Exchange	7	9,763	1.3%
ACA Compliant			
Off-Exchange	18	319,617	42.9%
Total	**29**	**744,446**	**100.0%**
Non-ACA Compliant			
Off-Exchange	16	42,184	5.7%
ACA Compliant			
Off-Exchange	18	482,821	64.9%
Federally Facilitated Marketplace	6	219,441	29.5%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2021.

[a] Company count column does not add up to total because an insurer may have more than one market segment.

Metal Tier Plans (Actuarial Value). ACA compliant plans also can be classified by actuarial value. Below is a summary of membership by the actuarial value of plans on the FFM. Actuarial value is a method to measure the relative cost-sharing value of health benefit plans. For example, a Gold plan covers approximately 80 percent of the eligible health care costs under the health benefit plan. The member is responsible for the rest. By comparison, a Bronze plan only covers about 60 percent of the eligible health care costs under the health benefit plan, and the member is responsible for a higher portion of the cost. Starting in 2018, Bronze plans included a subcategory called the extended Bronze plan. An extended Bronze plan may include benefit options that approach the average actuarial value of 60 percent, but the actuarial value may range from 56 percent to 65 percent. Health benefit plans with a higher actuarial value are usually more expensive and those with a lower actuarial value are usually less expensive. However, the cost that individual consumers pay may differ significantly depending on their individual circumstances.

A majority of members on the FFM were enrolled in Bronze plans (49.5 percent), followed by Silver plans (48.9 percent), Gold plans (1.4 percent), and Catastrophic plans (less than 1 percent). Under the ACA, Catastrophic plans are only available in the individual market to individuals under the age of 30 or those with a hardship exemption (see Table 17).

Table 17. Metal Tier Plans on Federally Facilitated Marketplace for 2021

Market Segment by Metal Tier	Member Count	Percent of Members
Federally Facilitated Marketplace	**219,441**	**100.0%**
Platinum (90% AV)	0	0.0%
Gold (80% AV)	3,014	1.4%
Silver (70% AV)	107,281	48.9%
Bronze (60% AV)	108,705	49.5%
Catastrophic	441	0.2%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2021. There were 6 commercial health insurers participating in the Federally Facilitated Marketplace during 2021.

HSA-Qualified High Deductible Health Plans. HSA-Qualified High Deductible Health Plans are high deductible health plans that can be combined with a savings account called a Health Savings Account (HSA). The deductible levels of these plans are set by federal statute and plans must comply with federal guidelines to qualify for use with an HSA. Payments made into an HSA are tax deductible and can be used to pay for current health care expenses or saved for the future. When the health care expenses reach the level of the deductible, the high deductible health plan pays for covered health care expenses beyond the deductible. High deductible health plans can also be used in conjunction with Health Reimbursement Arrangements (HRA). HRAs are similar to HSAs, except the employer owns the savings account (rather than the individual) and only the employer can deposit funds into the account. There were 298,414 members (about 40 percent of the market) enrolled in HSA-Qualified High Deductible Health Plans (see Table 18).

Standard Plans. Standard plans are simply the typical health benefit plan that operates under the current statutory requirements of the Utah insurance code and does not qualify for or make use of any of the features available under HSA-Qualified High Deductible Health Plans. Most health benefit plans in Utah's health insurance market are Standard Plans. There were 446,032 members (nearly 60 percent of the market) enrolled in Standard Plans (see Table 18).

Table 18. HSA-Qualified High Deductible Health Plans for 2021

Market Segment by Group Size	Member Count	Percent of Members
Individual	**253,344**	**34.0%**
HSA-Qualified High Deductible Health Plan	54,158	7.3%
Standard Plan	199,186	26.8%
Small Group	**161,722**	**21.7%**
HSA-Qualified High Deductible Health Plan	78,038	10.5%
Standard Plan	83,684	11.2%
Large Group	**329,380**	**44.2%**
HSA-Qualified High Deductible Health Plan	166,218	22.3%
Standard Plan	163,162	21.9%
Total	**744,446**	**100.0%**
HSA-Qualified High Deductible Health Plan	298,414	40.1%
Standard Plan	446,032	59.9%

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding. Data is current as of Dec. 31, 2021.

Membership in HSA-Qualified High Deductible Health Plans has grown steadily in Utah. In 2012, about 19 percent of the comprehensive health insurance market was enrolled in an HSA-Qualified High Deductible Health Plan. Since 2012, the percentage of the comprehensive membership covered by an HSA-Qualified High Deductible Health Plan has increased by 2.1 percent per year on average. As of 2021, HSA-Qualified High Deductible Health Plan membership accounts for about 40 percent of the market.

Comprehensive Market Trends

This section reports on four significant trends in Utah's comprehensive health insurance market: the number of insurers, the number of insured members, the cost of insurance, and the financial status of the market. Each measure represents a different aspect of the market's "health."

Trends in the number of insurers. The Insurance Department continues to monitor the number of commercial health insurance companies that are providing comprehensive health insurance. As shown in Table 19, the number of comprehensive health insurers declined from 2012 to 2020. In 2012, fifty-seven commercial health insurance companies reported comprehensive health insurance. By 2020, this number had dropped to 27. During 2021, the number of comprehensive health insurers increased to 29. The decline from 2012 to 2020 has primarily been among very small foreign insurers with less than $1 million in premium, although small insurers have also contributed to this decline in recent years. In contrast, the number of large insurers has remained stable, while medium insurers have fluctuated. These carriers account for more than 95 percent of the market. From 2014 to 2021, there has been some market shifting including several new insurers that entered the market to participate in the Federally Facilitated Marketplace (FFM). Recent improvements in premium income and market stability have made it easier for health insurers to participate. Six comprehensive health insurers participated in the FFM during 2021.

Table 19. Changes in the Number of Comprehensive Health Insurers: 2012 - 2021

Insurer Category	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	*Net Change*
Domestic Insurers											
Greater than 100 Million	3	3	3	4	4	3	3	3	3	3	*0*
Between 10 and 100 Million	0	0	2	4	4	5	3	1	3	3	*+3*
Between 1 and 10 Million	4	4	5	3	5	3	4	6	4	4	*0*
Less than 1 Million	2	1	1	1	0	1	1	1	1	2	*0*
Total Domestic	**9**	**8**	**11**	**12**	**13**	**12**	**11**	**11**	**11**	**12**	***+3***
Foreign Insurers											
Greater than 100 Million	1	1	1	1	1	1	1	1	2	2	*+1*
Between 10 and 100 Million	6	6	5	5	5	5	4	4	3	3	*-3*
Between 1 and 10 Million	9	7	5	3	2	2	2	2	2	3	*-6*
Less than 1 Million	32	29	27	18	17	17	13	10	9	9	*-23*
Total Foreign	**48**	**43**	**38**	**27**	**25**	**25**	**20**	**17**	**16**	**17**	***-31***
All Insurers											
Greater than 100 Million	4	4	4	5	5	4	4	4	5	5	*+1*
Between 10 and 100 Million	6	6	7	9	9	10	7	5	6	6	*0*
Between 1 and 10 Million	13	11	10	6	7	5	6	8	6	7	*-6*
Less than 1 Million	34	30	28	19	17	18	14	11	10	11	*-23*
Total Utah	**57**	**51**	**49**	**39**	**38**	**37**	**31**	**28**	**27**	**29**	***-28***

Data Source: Utah Accident & Health Survey

Note: Comprehensive health insurers are counted by relative size, broken into four categories of direct earned premium measured in millions of US dollars.

The typical comprehensive health insurer needs to be large enough to be able to drive membership volume to providers in order to remain competitive. While there is no absolute rule for how large an insurer needs to be, an insurer with a large number of members has more leverage in contract negotiations with providers. This arrangement can benefit both consumers and providers. Consumers may benefit from lower prices and providers may benefit from a higher volume of clients. Many small comprehensive health insurers cannot "drive volume" as effectively as a large insurer.

Most of the decline in the number of comprehensive health insurers has occurred primarily among very small comprehensive health insurers; particularly foreign insurers with less than $1 million in comprehensive health insurance premium (see Table 19). In many cases, these very small foreign comprehensive health insurers are providing coverage for "non-situated" policies, which are commercial health insurance policies that are issued in another state to an employer with less than 25 percent of their employees living in the state of Utah. The premium is reported as covering a Utah resident, but the policy itself was not sold in Utah. Many of these companies are not actively selling health insurance in the Utah health insurance market and are only here because they sold a health insurance policy to a company that has an employee who is currently a resident in the state. As a result, many of these insurers leave the market when the employees leave the company. Thus, many of these very small foreign comprehensive health insurers are covering a special class of Utah residents and may not be competing directly in the mainstream health insurance market in Utah. During 2021, there was a small increase in the number of comprehensive health insurers, one small and one very small.

The total number of medium insurers (between $10 to $100 million in premiums) remained relatively stable from 2010 to 2013, although there was a temporary decline in the number of domestic medium insurers and an increase in the number of foreign medium insurers. From 2013 to 2017, there was some turnover and several new medium sized insurers entered the market, including several new domestic insurers that entered the market to participate in the FFM. During 2018 and 2019, the number of medium sized insurers declined as the market shifted with several insurers decreasing in size. The number of medium sized insurers increased during 2020. The number of medium sized insurers remained unchanged during 2021.

Large comprehensive health insurers represent the core of the comprehensive health insurance market. These large insurers account for more than 85 percent of the market. These insurers provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market. During 2019, Molina Healthcare of Utah, SelectHealth, Inc., and University of Utah Insurance Plans participated in the FFM. During 2020, Cigna Health & Life Insurance Company and Bridgespan Health Company also entered the FFM, bringing the number of health insurers on the FFM to five. During 2021, Regence BlueCross BlueShield of Utah entered the FFM, bringing the numbers of insurers on the FFM to six.

With the changes in the number of medium sized insurers and the continuing decline in the number of small and very small insurers, the market has become more concentrated at the top, with more large and medium insurers and fewer small and very small insurers. Increased federal regulation and higher costs of doing business due to these regulations may make it harder

for small and very small insurers to participate. The small increase in the number of insurers during 2021 has not changed this pattern.

Trends in the number of members by group size. Since 2012, the number of residents insured by comprehensive health insurance as a relative percentage of Utah's total population has declined by about 5.4 percent. During this same time period, Utah's population has increased by about 17 percent. In absolute numbers, comprehensive membership has averaged about 765,000 members over the last ten years (about 25 percent of Utah's population in any given year). Year to year changes has been less than 38,100 members (see Table 20). During 2021, comprehensive membership increased by about 5.4 percent. This increase appears to be due to changes in the individual and small group markets.

Starting in 2014, the number of members in the individual market began to grow significantly. Membership increased by more than 80,000 during 2014 through 2016. Most of this growth was driven by the federal individual mandate which required most persons to maintain health insurance, the availability of coverage through the FFM, where persons whose income is between 100 percent and 400 percent of the federal poverty level receive subsidies to make coverage more affordable, and changes to health insurance regulations, including guaranteed issue and community rating, which have made it easier for Utah residents to get and keep coverage in the individual market.

During 2017, the individual market declined by over 32,000 members. This appears to be due to several factors. This decline occurred among individuals with Off-Exchange plans who pay the full cost of any premium increases in the individual market and do not receive any subsidies under the ACA to make coverage more affordable. Membership in FFM plans, where most members have premium subsidies, did not experience the same change. Other factors may include significant market uncertainty during 2017 regarding rising health care costs and how changes to federal government regulations and the ACA would affect consumers, such as the ending of CSR payments and the possibility of the repeal of the ACA. This decline is also consistent with the increase in the uninsured rate during 2017. During 2018, membership in the individual market remained stable, followed by an increase of over 11,000 members during 2019 and 2020. This change appears to be due to steady growth in FFM membership and the availability of enhanced APTC payments during this period.

During 2021, membership in the individual market increased significantly. The number of members in the individual market, driven by growth in FFM membership, increased by more than 35,000. This growth appears to be related to the American Rescue Plan Act of 2021 (ARPA) (American Rescue Plan Act, 2021). The APRA was designed to assist persons effected by the COVID-19 pandemic, which includes expanded premium tax credits for individuals who are eligible for the FFM and also offers subsidies to persons with incomes greater than 400 percent of the federal poverty level. The ARPA provisions are temporary and were scheduled to last until the end of 2022 but have been extended through 2025 under the Inflation Reduction Act of 2022.

Membership in the small group market declined from 2016 to 2019. This decline in small group membership followed premium increases in the small group markets during this period. It is also possible that some small group membership may have shifted to the individual market, and healthy small groups may have moved to self-funded health benefit plan arrangements to circumvent several of the ACA provisions. Small group market membership remained stable during 2020 and then increased during 2021 to a level similar to 2018. The number of members covered by stop-loss policies that were issued to small group self-funded plans increased from less than 2,000 during 2014 to over 25,000 during 2021.

Large group membership declined during 2012, due to several blocks of business shifting to self-funded health benefit plans. During 2013, the large group market made a slight recovery and increased membership, followed by a period of decline from 2014 to 2016. Large group membership was stable during 2017 and then declined from 2018 to 2021. These changes are probably due to some employers moving to self-funding arrangements, although one cannot rule out the possibility of some shifting to the individual market or short-term limited duration plans. ACA regulations are most likely increasing self-funded arrangements as well.

Trends in the number of members by plan type. From 2012 to 2013, there was a shift away from FFS plans to PPO plans. The change in FFS plan membership is consistent with national surveys that have also found a decline in FFS plans. For example, the Kaiser Employer Health Benefits Survey also reported lower estimates of insured membership in FFS plans during this period (Kaiser/HRET, 2013, Kaiser/HRET, 2014). This may be due to rising health care costs, with consumers, employers, and insured moving towards less expensive managed care options such as PPO plans, HMO plans, and HMO with POS plans. Conversations with commercial health insurers also suggest that the shift from FFS plans to PPO plans may be due to rational economic behavior by consumers who are choosing lower cost managed care options like PPO plans over FFS plans as a result of rising health care costs and difficult economic conditions.

During 2016, the number of members in FFS and HMO plans increased, while PPO and HMO with POS plans decreased. The increase in HMO plans appears to be due to a shift from HMO to POS plans to HMO plans within the market. HMO plans increased from 8.9 percent during 2015 to 9.7 percent in 2016. A number of new EPO plans also entered the market during 2016, but their market share was very small (see Table 21).

Table 20. Changes in Comprehensive Membership by Group Size: 2012 - 2021

Group Size	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	*Net Change* [a]
Individual	156,426	158,047	204,601	226,927	238,637	205,992	206,222	210,215	217,524	253,344	*+96,918*
Percent of population [b]	**5.5%**	**5.4%**	**7.0%**	**7.6%**	**7.8%**	**6.6%**	**6.5%**	**6.6%**	**6.6%**	**7.6%**	***+2.1%***
Small Group	212,591	195,398	187,580	192,306	177,948	173,004	161,316	155,776	155,963	161,722	*-50,869*
Percent of population	**7.5%**	**6.7%**	**6.4%**	**6.4%**	**5.8%**	**5.6%**	**5.1%**	**4.9%**	**4.8%**	**4.8%**	***-2.7%***
Large Group	420,789	439,873	418,070	406,876	375,818	375,322	354,309	346,556	332,988	329,380	*-91,409*
Percent of population	**14.8%**	**15.2%**	**14.2%**	**13.6%**	**12.3%**	**12.1%**	**11.2%**	**10.8%**	**10.2%**	**9.9%**	***-4.9%***
Total Group	633,380	635,271	605,650	599,182	553,766	548,326	515,625	502,332	488,951	491,102	*-142,278*
Percent of population	**22.2%**	**21.9%**	**20.6%**	**20.0%**	**18.1%**	**17.7%**	**16.3%**	**15.7%**	**14.9%**	**14.7%**	***-7.5%***
Total Comprehensive	789,806	793,318	810,251	826,109	792,403	754,318	721,847	712,547	706,475	744,446	*-45,360*
Percent of population	**27.7%**	**27.3%**	**27.5%**	**27.6%**	**26.0%**	**24.3%**	**22.8%**	**22.2%**	**21.6%**	**22.3%**	***-5.4%***
Utah Population	2,852,589	2,900,872	2,942,902	2,995,919	3,051,217	3,101,833	3,161,105	3,205,958	3,271,616	3,337,975	*+485,386*
Percent of population	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	***0.0%***

Data Sources: Utah Accident & Health Survey, Utah Population Estimates Committee, and the U.S. Census Bureau.

Note: Estimates may not add up exactly to totals due to rounding.

[a] "Net Change" measures the difference in the absolute number of members from 2012 to 2021 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 17 percent during this period.

[b] "Percent of population" estimates the membership as a relative percentage of Utah's total population in each particular year.

Table 21. Changes in Comprehensive Membership by Plan Type: 2012 - 2021

Plan Type [a]	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	*Net Change* [b]
FFS	17,021	14,135	19,971	15,018	21,621	20,051	19,863	21,049	21,890	19,912	*+2,891*
Percent of population [c]	**0.6%**	**0.5%**	**0.7%**	**0.5%**	**0.7%**	**0.6%**	**0.6%**	**0.7%**	**0.7%**	**0.6%**	***0.0%***
PPO	273,791	288,683	251,606	248,071	234,642	237,760	197,909	195,821	180,830	170,891	*-102,900*
Percent of population	**9.6%**	**10.0%**	**8.5%**	**8.3%**	**7.7%**	**7.7%**	**6.3%**	**6.1%**	**5.5%**	**5.1%**	***-4.5%***
EPO	-	-	-	-	4,052	5,138	24,590	22,977	25,355	25,226	*+25,226*
Percent of population	**-**	**-**	**-**	**-**	**0.1%**	**0.2%**	**0.8%**	**0.7%**	**0.8%**	**0.8%**	***+0.8%***
HMO	176,088	181,002	243,636	267,842	294,663	268,340	265,380	270,375	278,237	347,315	*+171,227*
Percent of population	**6.2%**	**6.2%**	**8.3%**	**8.9%**	**9.7%**	**8.7%**	**8.4%**	**8.4%**	**8.5%**	**10.4%**	***+4.2%***
HMO with POS	322,906	309,498	295,038	295,178	237,425	223,029	214,105	202,321	200,163	181,102	*-141,804*
Percent of population	**11.3%**	**10.7%**	**10.0%**	**9.9%**	**7.8%**	**7.2%**	**6.8%**	**6.3%**	**6.1%**	**5.4%**	***-5.9%***
Total Comprehensive	789,806	793,318	810,251	826,109	792,403	754,318	721,847	712,547	706,475	744,446	*-45,360*
Percent of population	**27.7%**	**27.3%**	**27.5%**	**27.6%**	**26.0%**	**24.3%**	**22.8%**	**22.2%**	**21.6%**	**22.3%**	***-5.4%***
Utah Population	2,852,589	2,900,872	2,942,902	2,995,919	3,051,217	3,101,833	3,161,105	3,205,958	3,271,616	3,337,975	*+485,386*
Percent of population	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	***0.0%***

Data Sources: Utah Accident & Survey, Utah Population Estimates Committee, and the U.S. Census Bureau.

Note: Estimates may not add up exactly to totals due to rounding. Estimate totals may differ from previous reports due to category changes.

[a] Plan Types Key: FFS = Fee For Service / Indemnity, PPO = Preferred Provider Organization, EPO = Exclusive Provider Organization, HMO = Health Maintenance Organization, HMO with POS = Health Maintenance Organization with Point of Service features

[b] "Net Change" measures the difference in the absolute number of members from 2012 to 2021 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 17 percent during this period.

[c] "Percent of population" measures the plan membership as a relative percentage of Utah's total population in each particular year.

During 2017, the total number of members in the comprehensive market decreased by nearly 5 percent. Most of this change was due to reductions in the number of members in HMO and HMO with POS plans. The decline in the number of members in HMO plans accounted for the majority of the change, while the decline in the number of members in HMO with POS plans accounted for most of the remaining change. The number of members in PPO and EPO plans increased, while HMO, HMO with POS, and FFS plans decreased. HMO plan membership declined by 8.9 percent. HMO with POS plan membership declined by 6.1 percent. EPO plan membership increased, but the EPO plan market share remained very small.

During 2018, the total number of members in the comprehensive market decreased by over 4 percent. Most of this change was due to a reduction in the number of members in PPO plans and HMO with POS plans. PPO plan membership declined by nearly 17 percent and HMO with POS plan membership declined by 4 percent. In contrast, EPO plan membership increased substantially, growing from about 5,000 during 2017 to over 24,000 during 2018. EPO plan membership is now greater than the FFS plan membership.

During 2019, the total number of members in the comprehensive market decreased by about 1 percent. Most of this change was due to a reduction in the number of members in PPO plans, EPO plans, and HMO with POS plans. PPO plan membership declined by 1 percent, EPO plan membership declined by 6.6 percent, and HMO with POS plan membership declined by 5.5 percent. In contrast, FFS plans and HMO plans increased. FFS plan membership increased by 6 percent and HMO plan membership increased by nearly 2 percent.

During 2020, the total number of members in the comprehensive market decreased by about 0.9 percent. Most of this change was due to a reduction in the number of members in PPO and HMO with POS plans. Membership in EPO and HMO plans increased while membership in FFS plans remained stable. Increases in the number of members with EPO and HMO plans were associated with increases in individual policies issued through the FFM.

During 2021, the total number of members in the comprehensive market increased by 5.4 percent. Most of this change was due to a significant increase in the number of members in HMO plans. There was a decline in the number of members for FFS, PPO, EPO, and HMO with POS. FFS plan membership declined by 9 percent, PPO plan membership declined by 5.5 percent, EPO plan membership declined by 0.5 percent, and HMO with POS plan membership declined by 9.5 percent. These declines were offset, however, by a significant increase in HMO plan members, which increased by nearly 25 percent. The growth in the number of members with HMO plans was primarily driven by an increase in individual policies issued through the FFM (see Table 21).

Government sponsored health benefit plans. Data on government sponsored health benefit plans in Utah continues to shows a steady increase in membership (see Table 22). Most of the increases are in Medicare and Medicaid. During 2014, there was a large shift from the Children's Health Insurance Program (CHIP) to Medicaid. This was due to changes required by the ACA, which required states to shift children in families with incomes between 100 percent and 138 percent of the federal poverty level out of CHIP and into Medicaid. Medicaid membership also increased significantly during 2020 and 2021. On January 1, 2020, adults age 19-64 with household incomes up to 138 percent of the federal poverty level became eligible for Medicaid in Utah.

Table 22. Changes in Government Sponsored Health Benefit Plans: 2012 - 2021

Plan Type	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	*Net Change* [a]
Medicare	304,202	317,413	329,943	340,968	355,492	371,770	398,399	424,323	410,689	428,379	*+124,177*
Medicaid	257,691	268,393	287,736	295,123	297,552	298,251	303,913	317,353	366,428	455,927	*+198,236*
CHIP	36,893	35,343	15,760	16,588	18,577	19,651	18,959	17,512	16,354	9,521	*-27,372*
PCN	16,734	16,134	14,021	13,203	17,304	13,605	13,222	-	-	-	*-16,734*
HIPUtah	3,381	2,900	-	-	-	-	-	-	-	-	*-3,381*
Federal HIPUtah	1,168	-	-	-	-	-	-	-	-	-	*-1,168*
Government Plans	620,069	640,183	647,460	665,882	688,925	703,277	734,493	759,188	793,471	893,827	*+273,758*
As percent of population [b]	**21.7%**	**22.1%**	**22.0%**	**22.2%**	**22.6%**	**22.7%**	**23.2%**	**23.7%**	**24.3%**	**26.8%**	***+5.1%***

Data Sources: Centers for Medicare and Medicaid Services, Utah Department of Health, and HIPUtah.

Note: Estimates may not total exactly due to rounding. This table reports the following Government Sponsored Health Benefit Plans in Utah: Medicare, Medicaid, Children's Health Insurance Program (CHIP), Primary Care Network (PCN), Utah Comprehensive Health Insurance Pool (HIPUtah), and the Federal Pre-Existing Condition Insurance Plan (Federal HIPUtah). The Federal HIPUtah program ended in 2013. The HIPUtah program ended in 2014.

[a] "Net Change" measures the difference in the absolute number of members from 2012 to 2021 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 17 percent over this period.

[b] "As percent of population" measures the relative percentage of Utah's total population in each particular year.

Estimates of the uninsured. Data from the Census Bureau's American Community Survey estimates Utah's uninsured rate to be 9.0 percent for 2021 (Conway and Branch, 2022). Due to the impact of the COVID-19 pandemic on data collection, the Census Bureau has not published state and local uninsured estimates for 2020 (Keisler-Starkey and Bunch, 2021). Previous data from the Census Bureau's American Community Survey estimates Utah's uninsured rate to be 9.7 percent for 2019 (Keisler-Starkey and Bunch, 2020), 9.4 percent for 2018 (Berchick, Barnett, and Upton, 2019), 9.2 percent for 2017 (Berchick, Hood, and Barnett, 2018), and 8.8 percent for 2016 (Barnett and Berchick, 2017).

Health care sharing ministries. Health care sharing ministries (HCSMs) are non-profit 501(c)(3) organizations created to assist their members with health care costs. Members share a common set of religious beliefs and make monthly payments that are used to pay for the health care expenses of other members.

HCSMs are not health insurance. HCSMs are exempt from state regulation and are not regulated by the Insurance Department. HCSMs do not have to comply with the consumer protections under the ACA (Patient Protection Affordable Care Act, 2010).

The Insurance Department has attempted to estimate how many individuals are enrolled in HCSMs in Utah. Based on the available information provided by HCSMs operating in Utah, the Insurance Department estimates that approximately 32,000 Utah residents were enrolled in a HCSM during 2021. This estimate should be used with caution. The Insurance Department does not have a complete list of HCSMs operating in Utah and this estimate may not include all Utah residents enrolled in an HCSM.

Trends in the cost of insurance. Utah's comprehensive health insurance premiums have increased over the last 10 years. For example, from 2012 to 2021, the average premium per member per month for comprehensive health insurance has increased on average by about 5.1 percent per year. However, the COVID-19 pandemic during 2020 impacted health care costs in ways that are still being understood. In 2021, premium growth slowed and the average premium per member per month for comprehensive health insurance was only 0.5 percent higher than in 2020 (see Table 23). This is due to comprehensive health insurers in the individual and small group markets setting rates at levels similar to or slightly lower than 2020.

Table 23. Comprehensive Premium Compared to National Economic Trends: 2012 – 2021

	Comprehensive Premium in Utah				National Economic Trends
Year	Total Premium [a]	Premium PMPM [b]	Premium PMPY [c]	Annual Percent Change	Health Insurance Premium Annual Percent Change [d]
2012	$2,324,561,535	$247	$2,964	2.9%	4.5%
2013	$2,423,407,576	$259	$3,108	4.9%	3.8%
2014	$2,670,928,970	$277	$3,324	6.9%	3.0%
2015	$2,767,877,369	$280	$3,360	1.1%	4.2%
2016	$2,929,832,909	$300	$3,600	7.1%	3.4%
2017	$3,020,205,133	$330	$3,960	10.0%	3.4%
2018	$3,325,579,764	$379	$4,548	14.8% [e]	4.5%
2019	$3,287,778,900	$383	$4,596	1.1%	4.9%
2020	$3,295,470,583	$386	$4,632	0.8%	3.7%
2021	$3,392,957,126	$388	$4,656	0.5%	4.1%

Data Sources: Utah premium data are from the Utah Accident & Health Survey from 2012 to 2021. The national trend data used as a comparison comes from the 2021 Kaiser Family Foundation Employer Health Benefits Survey.

[a] Total direct earned premium
[b] Direct earned premium per member per month
[c] Direct earned premium per member per year
[d] "Health Insurance Premium" trends are based on premium changes for family coverage under an employer based plan.
[e] The federal government ended the CSR payment program which required comprehensive health insurers to raise rates higher than they would have been had the CSR payments continued.

One of the main causes of the general trend towards higher premiums is a steady increase in the underlying cost of health care. For example, from 2012 to 2021, the average losses per member per month for comprehensive health insurance increased by about 5.6 percent per year. During 2020, the COVID-19 pandemic changed health care spending patterns, but health insurers did not report a significant increase in health care costs. In 2021, the average losses per member per month for comprehensive health insurance were 5.0 percent higher than in 2020 (see Table 24). This increase may be due to pent-up demand in health care services related to the COVID-19 pandemic during 2020, which appears to have reduced health care spending in some areas due delays in elective health care and social distancing guidelines.

Historically, health care costs have been driven by multiple factors, including changes in medical technology, pharmaceutical costs, government regulations, payment models, demographics, lifestyle choices, and general inflation (PriceWaterhouseCoopers, 2018). Utilization of health care services and unit prices of health care continue to be important factors (PriceWaterhouseCoopers, 2017). Other studies have also found evidence of excess spending in the areas of unnecessary medical services, administrative costs and complexity, fraud and abuse, and the pricing of services (Institute of Medicine, 2012; Shrank, Rogstad, and Parekh, 2019). Coverage expansions under the ACA and increases in retail prescription drug costs have also affected the cost of health care (Hartman, Martin, Espinosa, Catlin, and the National Health Expenditure Accounts Team, 2018). Prescription drug spending is growing faster than other types of health care spending (American Academy of Actuaries, 2018). Recent increases in the price of health care, particularly the price of prescription drugs has become a key area of focus as a way to manage rising healthcare costs (PriceWaterhouseCoopers, 2017; PriceWaterhouseCoopers, 2018).

Table 24. Comprehensive Losses Compared to National Health Care Spending: 2012 - 2021

	Comprehensive Losses in Utah				National Health Care Expenditures (in Millions of Dollars)			
Year	Loss Ratio [a]	Losses PMPM [b]	Losses PMPY [c]	Annual Percent Change	Total NHE (All Sources)	Annual Percent Change	NHE for Private Health Insurance Only	Annual Percent Change
2012	83.61	$206	$2,475	0.1%	$2,782,804	4.0%	$877,800	3.2%
2013	83.54	$216	$2,592	4.7%	$2,855,822	2.6%	$878,867	0.1%
2014	87.96	$244	$2,928	13.0%	$3,001,434	5.1%	$921,867	4.9%
2015	95.34	$267	$3,204	9.4%	$3,163,647	5.4%	$975,648	5.8%
2016	92.92	$279	$3,348	4.5%	$3,305,581	4.5%	$1,029,776	5.5%
2017	89.07	$294	$3,528	5.4%	$3,446,492	4.3%	$1,079,066	4.8%
2018	83.09	$315	$3,780	7.1%	$3,604,511	4.6%	$1,130,967	4.8%
2019	84.39	$323	$3,876	2.5%	$3,759,123	4.3%	$1,165,571	3.1%
2020	83.13	$321	$3,852	-0.6%	$4,124,005	9.7%	$1,151,356	-1.2%
2021	86.66	$337	$4,044	5.0%	$4,297,112	4.2%	$1,224,217	6.3%

Data Sources: Utah loss data are from the Utah Accident & Health Survey from 2012 to 2021. The National Health Care Expenditure data are from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary (2021). NHE historical data were used for 2012 to 2020. NHE projected data were used for 2021.

[a] Ratio of direct incurred losses to direct earned premium
[b] Direct incurred losses per member per months
[c] Direct incurred losses per member per year

National health care spending grew faster during 2014 compared to the previous five years. This growth was driven primarily by the major coverage expansions under the ACA, particularly for Medicaid and private health insurance (Martin, Hartman, Benson, Catlin, and the National Health Expenditure Accounts Team, 2016). Growth in national health costs for employer groups was modest during 2014 (Claxton, Rae, Panchal, Whitmore, Damico, and Kenward, 2014; Kaiser/HRET, 2015), while costs in the individual market increased significantly as people shifted to ACA compliant plans, and as previously uninsured or higher risk individuals obtained insurance in the individual market.

National health costs for employer groups were stable during 2015 continuing a pattern of more modest growth (Claxton, Rae, Panchal, Whitmore, Damico, Kenward, and Long, 2015; Kaiser/HRET, 2016). Growth in health spending was slower during 2016. This change was broad-based, as spending by payer and by service decelerated. Slower enrollment trends under the ACA also contributed to this slowdown (Hartman, Martin, Espinosa, Catlin, and the National Health Expenditure Accounts Team, 2018). Health care spending slowed during 2017. This slower growth was primarily due to reductions in the use and intensity of healthcare services for hospital care, physician services, and retail drugs (Martin, Hartman, Washington, Catlin, and the National Health Expenditure Accounts Team, 2019). Health care spending increased during 2018. This increase was driven by growth in Medicare and private insurance spending (Hartman, Martin, Benson, Catlin, and the National Health Expenditure Accounts Team, 2020).

National health care spending during 2019 grew at a similar rate as 2018 (Martin, Hartman, Lassman, Catlin, and the National Health Expenditure Accounts Team, 2021). Recent estimates of national health care spending for 2020 reported a significant increase in health care spending compared to 2019. Total health care spending increased by 9.7 percent. This was primarily due to a significant increase in federal spending in response to the COVID-19 pandemic (Hartman, Martin, Washington, Catlin, and the National Health Expenditure Accounts Team, 2022). However, health care spending for private health insurance declined by 1.2 percent during 2020 due to reduced or delayed health care services in response to the COVID-19 pandemic (Centers for Medicare and Medicaid Services, 2022b).

The COVID-19 pandemic is expected to continue to affect national health care spending in the near future. Projections estimate that national health care spending growth is expected to slow from 9.7 percent in 2020 to 4.2 percent in 2021. This is mainly due to the decline in federal spending in response to COVID-19. National health care spending is projected to normalize by 2024 and grow by about 5.3 percent per year during 2025 to 2030 (Poisal, Sisko, Cuckler, Smith, Keehan, Fiore, Madison, and Rennie, 2022).

The cost of health care continues to create significant economic pressure on comprehensive health insurers. For example, if Utah's comprehensive health insurers had kept premiums at 2012 levels and costs had continued to increase, by 2021, the industry's loss ratio would be approximately 136. In other words, the industry would be paying out nearly $1.36 in claims for every $1.00 in premium. No business can afford to lose money at such rates for long, so comprehensive insurers responded by raising premiums to levels that would cover their costs. In addition to claim costs, comprehensive insurers also have to pay general administrative costs such as general business expenses and the cost of processing claims. Furthermore, commercial

health insurers are also required by state law to maintain adequate financial reserves and to remain financially solvent. This is because commercial health insurers are selling "a promise to pay in the future." When a consumer purchases a health insurance contract, they are buying a promise to pay for future health care costs under certain conditions. Insurers cannot pay claims on behalf of consumers without adequate funds to do so.

For Utah employers and consumers, this trend towards higher premiums means that health care continues to be expensive. For a single individual, the average premium per member per year increased from $2,964 in 2012 to $4,656 in 2021 (without taking into account any advance premium tax credits an individual may have received). This is an increase of about 57 percent over the last ten years. Both consumers and employers are being impacted by these increases. In most cases, employers pay a significant portion of this premium. Nationally, employers pay more than two-thirds of the premium cost (Kaiser Family Foundation, 2022). However, many employers are responding to the rising cost of health care by increasing the employee's portion of the premium, reducing benefits, increasing deductibles and cost sharing, or looking at new plan designs to reduce costs (Kaiser Family Foundation, 2022). These changes continue to be difficult for many consumers to absorb because the rate of increase in consumer income has not kept pace with the rate of increase in health care costs and, as a result, many consumers continue to struggle with the cost of using their health insurance to obtain necessary health care (see Table 25).

Table 25. Changes in Comprehensive Premium and Per Capita Income: 2012 - 2021

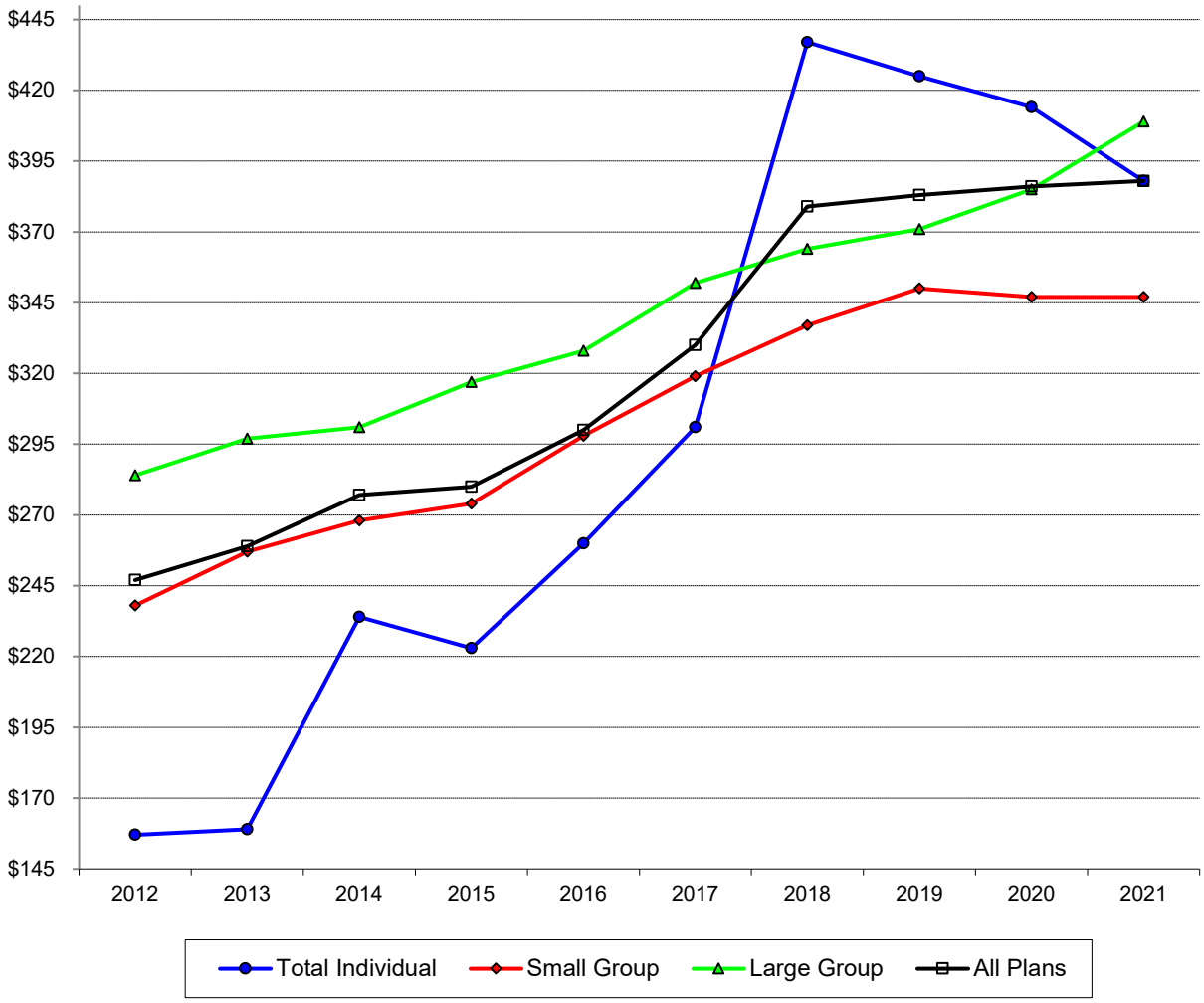
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Premium PMPY [a]	$2,964	$3,108	$3,324	$3,360	$3,600	$3,960	$4,548	$4,596	$4,632	$4,656
Percent change in Premium	2.9%	4.9%	6.9%	1.1%	7.1%	10.0%	14.8%	1.1%	0.8%	0.5%
Per Capita Income in Utah	$36,085	$36,628	$38,328	$40,668	$42,008	$43,711	$46,377	$49,115	$52,204	$53,859[e]
Percent change in Income	5.4%	1.5%	4.6%	6.1%	3.3%	4.1%	6.1%	5.9%	6.3%	3.2%

Data Sources: Utah premium data are from the Utah Accident & Health Survey. Per capita income data are from the 2022 Economic Report to the Governor, David Eccles School of Business and the Utah Governor's Office of Management and Budget.

[a] Direct earned premium per member per year
[e] Estimate

Prior to 2014, premium increases were relatively uniform among different group types. Premium increases were larger among small and large group plans, while individual plans reported lower increases over time. In 2014, that pattern changed. Under the ACA, policies are underwritten using community rating, which means that the insurance risk is spread over the entire community of insured members regardless of health status. This means that the cost of covering higher risk and lower risk individuals tends to average out, which can be beneficial to individuals with higher health care costs. Starting in 2014, the individual market began using a form of community rating to set rates, which included covering individuals with higher costs which has increased rates significantly. During 2021, individual premium per member per month declined by 6.3 percent. Changes in small group premiums per member per month remained small, while large group premiums per member per month increased by 6.2 percent. Individual premium per member per month was similar to the market average and large group premium per member per month was higher than the market average (see Figure 2).

Figure 2. Comprehensive Premium PMPM by Group Size: 2012 - 2021



Data Source: Utah Accident & Health Survey

One of the primary reasons for the increase in individual premium per member per month was the shift in the individual market to the community rating required by ACA compliant plans and expanded coverage for higher risk individuals starting in 2014. The mixture of market demographics of products and insured members within the individual market changed significantly and there was a rapid growth in the FFM as more people moved from non-ACA to ACA compliant plans.

Also, comprehensive health insurers did not have a full year's claim experience to use when pricing their products during 2014 and 2015. Comprehensive health insurers usually base their rates on previous experience in the market and current market trends. Due to the nature of the ACA marketplace, comprehensive health insurers did not have all of the information they needed to price their products. This made it difficult to set rates that would cover their actual costs.

During 2016, comprehensive health insurers had more claim experience to work with, but there was still considerable market uncertainty which made pricing their products difficult. Comprehensive health insurers were also basing their rates on the assumption that they would be receiving additional funding from the federal risk corridor program to help manage the costs of covering high risk individuals. However, due to changes to the federal funding of the risk corridor program made by the United States Congress, comprehensive health insurers did not receive the additional payments that were expected under the program that would have helped them cover their costs.

During 2017, comprehensive health insurers continued to experience significant market uncertainty, but using the more accurate pricing information now available, health insurers were able to demonstrate that higher premium rates were required to cover the actual risk that health insurers were experiencing and the termination of the risk corridor program. As a result of these recent rate increases, many comprehensive health insurers in the individual market experienced significantly lower loss ratios during 2017, and the general financial stability of health insurers in Utah began to improve. During October 2017, the federal government unexpectedly ended federal funding for the CSR payment program, which required health insurers to raise 2018 rates higher than they would have been had the CSR payments continued.

During 2018, due to the significant rate increases implemented in the individual market, premium income increased significantly which brought loss ratios down to more manageable levels and significantly improved comprehensive health insurers' financial stability. Premiums in the individual market were much more likely to cover comprehensive health insurers' claim costs and, in some cases, consumers and employers received premium rebates as required under the ACA.

During 2019, comprehensive premiums stabilized. Comprehensive health insurers generally maintained the rates that were set during 2018. Comprehensive claim costs stabilized and premiums were sufficient to cover comprehensive health insurers claim costs.

During 2020, comprehensive health insurers were impacted by the COVID-19 pandemic. In the spring of 2020, health care spending declined as consumers reduced elective health care to preserve hospital capacity and implement social distancing measures. Although other forms of health care spending increased, the net impact of the COVID-19 pandemic appears to have kept health care spending, health insurer loss ratios, and comprehensive premiums stable during 2020.

During 2021, comprehensive health insurers experienced uncertainty as to how the COVID-19 pandemic would affect the insurance market. Comprehensive health insurers responded to this uncertainty by setting rates in the individual and small group markets at levels similar to or slightly lower than 2020. Comprehensive health insurers in the individual market reported lower premium per member per month, but also reported higher loss ratios. Comprehensive health insurers in the large group market reported higher premium per member per month, but did not report higher loss ratios.

In the past, increases in large group plan premiums have had the most impact on the premium trends in the market. This is primarily due to the fact that more Utah residents in the comprehensive health insurance market are covered by large group plans than by any other type. As a result, changes in this category have had a larger impact on market averages than changes in the individual or small group markets. This has changed, and the individual market is having a much larger impact on the market average than in previous years.

Although Utah continues to experience significant increases in the cost of comprehensive health insurance coverage, when one compares Utah premiums on a per member per month basis to national data from the National Association of Insurance Commissioners (NAIC), Utah's premium appears to be lower than the national average (see Table 26). For example, during 2021, the average premium for Utah's comprehensive health insurers was approximately $388 per member per month. In contrast, the average premium for commercial health insurers reporting comprehensive health insurance to the NAIC financial database was approximately $498 per member per month. Although this comparison does not control for differences in benefits, health status, or demographics, this data suggests that Utah's average premium is lower than the average premium reported to the NAIC. Utah also has fewer health insurance mandates than many other states.

Table 26. Comparison of Utah Premium to National Premium: 2012 - 2021

	Utah Estimate		National Estimate	
Year	Premium PMPM for Comprehensive Health Insurance [a]	Annual Percent Change	Premium PMPM for Comprehensive Health Insurance	Annual Percent Change
2012	$247	2.9%	$320	2.9%
2013	$259	4.9%	$324	1.3%
2014	$277	6.9%	$348	7.4%
2015	$280	1.1%	$364	4.6%
2016	$300	7.1%	$389	6.9%
2017	$330	10.0%	$423	8.7%
2018	$379	14.8%	$461	9.0%
2019	$383	1.1%	$467	1.3%
2020	$386	0.8%	$486	4.1%
2021	$388	0.5%	$498	2.5%

Data Sources: Utah Accident & Health Survey and the NAIC Financial Database

Note: The Utah estimate is based on data obtained from the Utah Accident & Health Survey for comprehensive health insurance. The national estimate is based on data obtained from the NAIC Financial Database. The data represents the average premium per member per month for comprehensive health insurance business as reported by commercial health insurers who filed on the annual financial statement for health related insurance business. Both data sources include only information on commercial health insurers.

[a] Premium per member per month is the average premium per person per month for comprehensive health insurance. This is the estimated cost of health insurance for all types of hospital and medical coverage on a per person basis. A division into single and family rates is not possible using data from the Utah Accident & Health Survey or the NAIC Financial Database. This comparison does not control for differences in plan structure, covered benefits, health status, or demographics.

However, the premiums that consumers actually pay may differ significantly from the market average depending on their individual circumstances and plan choice. Furthermore,

although Utah's premiums may be lower by this measure, Utah's premiums are increasing at rates that are comparable to comprehensive health insurers nationally (5.1 percent for Utah, 5.0 percent for comprehensive health insurers reporting to NAIC), and continue to be financially challenging for many consumers.

Health insurance mandates. The ACA requires a comprehensive health insurance plan qualified to be sold on the Federally Facilitated Marketplace (FFM) to meet a minimum standard, or essential health benefits requirement. If a state requires an insurer to offer a benefit that exceeds the essential health benefits, the state must reimburse those costs through a defrayal payment, 45 C.F.R. 155.170. In 2019, the Utah Legislature passed SB95, Autism Amendments, requiring a comprehensive health insurer in the individual or large group market to provide coverage for behavioral health treatment for a person with an autism spectrum disorder, Utah Code § 31A-22-642(5)(b). The mandated coverage requirement as it applies to a comprehensive health insurance plan in the individual market and eligible to be sold on the FFM is subject to the federal defrayal payment requirement (see Table 27).

Table 27. State Benefit Mandate Defrayal Payments for Autism Behavioral Health Treatment: 2020 - 2021

Year	Member Months [a]	Defrayal Cost PMPM	State Defrayal Payments
2020	1,685	$1,253	$1,828,871
2021	2,362	$2,159	$4,630,581

Data Source: Utah Insurance Department

[a] The total months of coverage for members that received autism benefits during the year.

Financial trends. To measure the current financial condition of the market, the financial results of the major comprehensive health insurers in Utah were used as an index of Utah's comprehensive health insurance market. These companies were selected because: 1) they represent more than 80 percent of the comprehensive health insurance market, 2) a majority of their revenues come from Utah business, and 3) their business model is that of a comprehensive health insurer. These companies are Utah's best examples of comprehensive health insurers and they can provide an index of how well comprehensive health insurers are doing in the Utah market over time (see Figure 3).

Comprehensive health insurers, whether for-profit or non-profit, need enough income after expenses to fund state-mandated reserve requirements, to reinvest in new equipment and new markets, and to acquire and maintain needed capital. The results of this index indicate that Utah's comprehensive health insurance market has experienced an average financial gain of 2.3 percent in net income per year over the last 10 years. During 2021, these companies reported an average gain in net income of 4.0 percent. According to the NAIC, the industry average for net income after expenses for health insurers during 2021 was 1.8 percent, which indicates that Utah's comprehensive health insurers performed higher than the industry average during 2021.

The first three years of the full implementation of the ACA were financially difficult for Utah's core comprehensive health insurers. Comprehensive health insurers had limited claim history to work with and were unable to generate enough premium income to cover their losses.

Changes to the federal risk corridor program meant comprehensive health insurers did not receive the additional payments that were expected under the program that would have helped them cover their costs.

From 2014 through 2016, the combination of not having enough information to adequately price their products and not receiving the additional payments from the federal risk corridor program as expected produced higher losses for health insurers participating in the individual market and the FFM. Several comprehensive health insurers withdrew from the FFM due to concerns that these losses were not sustainable.

During 2017, the fourth year of the full implementation of the ACA was a mixture of financial and regulatory challenges combined with an increase in financial stability. Regulatory uncertainty such as the possible repeal of the ACA, elimination of the federal funding for cost-sharing reduction (CSR) payments, and reductions in advertising for the FFM created higher market uncertainty for both consumers and health insurers than would normally have existed under the ACA as written.

During October 2017, the federal government ended the federal funding for the CSR payment program, which required comprehensive health insurers to raise rates higher than they would have been had the CSR payments continued. The combination of higher premium revenue and more accurate pricing information for health insurers led to the beginning of a financial recovery. Comprehensive health insurers reported better financial results during 2017 than they did during the first three years of the full implementation of the ACA, suggesting that health insurers were returning to profitability.

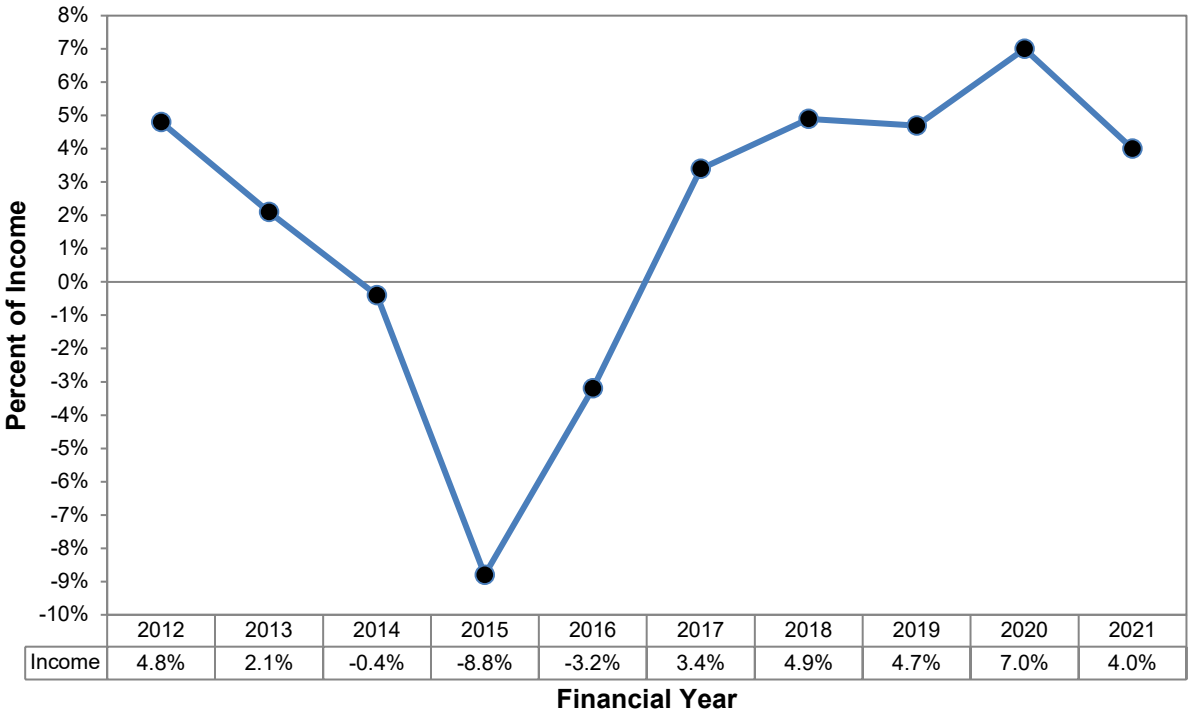
During 2018, the fifth year of the full implementation of the ACA, comprehensive health insurers reported significantly improved financial results. The high losses that were common from 2014 to 2016 were no longer occurring as the large rate increases that were implemented during 2017 and 2018 allowed health insurers to cover the cost of the health care services being provided for their members. The combination of higher premium revenue and more accurate pricing information, particularly in the individual market, has led to a financial recovery. Comprehensive health insurers reported a level of profitability not seen since prior to the full implementation of the ACA.

During 2019, the sixth year of the full implementation of the ACA, premium income stabilized and the financial pattern started in 2018 continued through 2019. Premiums remained stable with little increase. Higher premium income helped health insurers cover the cost of health care services that they were paying out for their members. Comprehensive health insurers reported positive financial results for the third year in a row.

During 2020, the seventh year of the full implementation of the ACA, net income increased significantly. This was due to a slight decline in health care spending caused by members delaying or forgoing healthcare treatment due to the COVID-19 pandemic, stable premium income and a one-time risk corridor payment from the federal government as a result of the final ruling in the Maine Community Health Options v. United States case.

During 2021, the eighth year of the full implementation of the ACA, net income declined compared to 2020. Although losses were higher during 2021, premium income remained stable and health insurers were able to cover the costs of their members' health care services. Comprehensive health insurers reported a level of profitability comparable to 2017 (see Figure 3).

Figure 3. Income After Expenses For Comprehensive Health Insurers: 2012 - 2021



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Income	4.8%	2.1%	-0.4%	-8.8%	-3.2%	3.4%	4.9%	4.7%	7.0%	4.0%

Data Source: NAIC Financial Database

Note: This figure represents the ratio of net income to total revenue as reported on the NAIC annual statement for the major managed care health insurers that have been operating in Utah from 2012 to 2021. Results are rounded to the nearest 0.1 percent.

Utah's Stop-Loss Insurance Market

Stop-loss insurance protects against unexpected or catastrophic claims. Stop-loss insurance makes up nearly 4 percent of the commercial health insurance market in the state of Utah (see Table 3). This section focuses on medical stop-loss insurance that provides insurance coverage for self-funded employer health benefit plans and is sold as an accident & health insurance product in Utah's commercial health insurance market. The following analysis of the medical stop-loss market examines various aspects of the market including market trends, state of domicile, group size, and coverage attachment points.

Stop-Loss Insurance Market Trends

Under the ACA, commercial and self-funded health benefit plans may not have annual or lifetime limits on essential health care benefits, which can increase the risk exposure for commercial and self-funded health benefit plans. Since the full implementation of the ACA, there appears to be an increased demand by self-funded employers who are looking for ways to manage risk and health care costs. From 2020 to 2021, the number of members covered by stop-loss insurance increased by about 4 percent (see Table 28).

Table 28. Total Stop-Loss Market: 2012 - 2021

Year	Company Count	Member Count	Direct Earned Premium	Loss Ratio
2012	41	385,949	$97,368,353	74.76
2013	37	393,157	$110,554,917	68.17
2014	38	483,290	$116,769,903	65.35
2015	41	468,760	$140,070,917	71.88
2016	44	607,058	$171,862,070	82.86
2017	46	625,174	$205,785,395	79.76
2018	48	591,099	$241,941,465	80.03
2019	46	649,783	$288,558,315	82.99
2020	42	663,501	$311,042,258	72.45
2021	43	691,963	$350,273,879	82.96
Average	**43**	**555,973**	**$203,422,747**	**76.12**

Data Source: Utah Accident & Health Survey

Stop-Loss Insurance Market by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state. Domestic insurers generally have a larger presence in their state of domicile than foreign insurers.

Approximately 75 percent of the stop-loss insurance market was served by 38 foreign insurers, with 5 domestic insurers covering the remaining 25 percent of the market. Premiums were higher for domestic insurers than foreign insurers with $64 per member per month for domestic insurers and $38 per member per month for foreign insurers. Loss ratios were higher for domestic insurers (see Table 29).

Table 29. Total Stop-Loss Market by Domicile for 2021

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [a]
Domestic	5	113,911	$87,665,527	25.03%	96.30	$64
Foreign	38	578,052	$262,608,352	74.97%	78.51	$38
Total	**43**	**691,963**	**$350,273,879**	**100.00%**	**82.96**	**$43**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

[a] Direct earned premium per member per month

Stop-Loss Insurance Market by Group Size

Stop-loss insurance plans are sold to self-funded employer plans. Some self-funded employer plans, especially small employers, purchase stop-loss insurance plans with lower attachment points to reduce their financial risk. Data was collected for three group sizes: Small Group (1 to 50 eligible employees), Large Group (51 to 100 eligible employees), and Large Group (101 or more eligible employees).

Table 30. Total Stop-Loss Market by Group Size for 2021

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Small Group (1-50)	12	25,163	$23,190,378	6.62%	90.36	$79
Large Group (51-100)	14	14,771	$17,463,976	4.99%	57.81	$103
Large Group (101 +)	38	652,029	$309,619,525	88.39%	83.83	$40
Total Stop-Loss	**43**	**691,963**	**$350,273,879**	**100.00%**	**82.96**	**$43**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

[a] Company count column does not add up to total because an insurer may have more than one group type.
[b] Direct earned premium per member per month

Large Group (51 to 100) reported the highest premium per member per month. Small Group (1 to 50) reported a higher premium per member per month than Large Group (101 or more). These higher premiums are probably due to differences in stop-loss coverage attachment points, with Small Group (1 to 50) and Large Group (51 to 100) reporting lower specific attachment points (see Table 30). Specific stop-loss is often more expensive than aggregate stop-loss and accounts for more of the premium. Large Group (101 or more) typically includes stop-loss coverage with higher specific and aggregate attachment points, which is consistent with their lower premium per member per month.

Stop-Loss Insurance Market by Attachment Points

Stop-loss insurance includes two types of coverage, specific and aggregate. These two types of coverage work together to protect a self-funded employer plan: specific stop-loss provides protection against the severity of unexpected claims, and aggregate stop-loss provides protection against the frequency of unexpected claims.

Specific stop-loss. Specific stop-loss (also known as individual stop-loss) provides protection for the employer plan against larger claims costs for a single covered individual. Specific stop-loss coverage includes a specified limit, or attachment point, when a stop-loss insurance policy will pay for an individual or a claim. The attachment point (also known as individual stop-loss deductible) is the dollar amount at which specific stop-loss protection reimburses the self-funded employer plan.

Table 31. Stop-Loss Membership by Specific Attachment Points for 2021

	Small Group (1 – 50)		Large Group (51 – 100)		Large Group (101 or more)		Total	
Attachment Point	Member Count	Percent of Total	Member Count	Percent of Total	Member Count	Percent of Total	Member Count	Percent of Total
NONE	-	-	51	< 0.1%	2,636	0.4%	2,687	0.4%
$10,000	2,376	0.3%	657	0.1%	464	0.1%	3,497	0.5%
$20,000	249	< 0.1%	696	0.1%	8,525	1.2%	9,470	1.4%
$30,000	12,573	1.8%	3,371	0.5%	15,862	2.3%	31,806	4.6%
$40,000	567	0.1%	1,349	0.2%	10,236	1.5%	12,152	1.8%
$50,000	381	0.1%	812	0.1%	39,621	5.7%	40,814	5.9%
$60,000	-	-	291	< 0.1%	5,229	0.8%	5,520	0.8%
$70,000	-	-	103	< 0.1%	13,216	1.9%	13,319	1.9%
$80,000	5	< 0.1%	3	< 0.1%	4,524	0.7%	4,532	0.7%
$90,000	-	-	-	-	2,404	0.3%	2,404	0.3%
$100,000	9,012	1.3%	7,438	1.1%	127,072	18.4%	143,522	20.7%
$200,000	-	-	-	-	101,878	14.7%	101,878	14.7%
$300,000	-	-	-	-	71,662	10.4%	71,662	10.4%
$400,000	-	-	-	-	55,999	8.1%	55,999	8.1%
$500,000	-	-	-	-	34,243	4.9%	34,243	4.9%
$600,000	-	-	-	-	13,965	2.0%	13,965	2.0%
$700,000	-	-	-	-	30,120	4.4%	30,120	4.4%
$800,000	-	-	-	-	1,470	0.2%	1,470	0.2%
$900,000	-	-	-	-	5,770	0.8%	5,770	0.8%
$1,000,000	-	-	-	-	91,282	13.2%	91,282	13.2%
$2,000,000 or more	-	-	-	-	15,851	2.3%	15,851	2.3%
Total	**25,163**	**3.6%**	**14,771**	**2.1%**	**652,029**	**94.2%**	**691,963**	**100.0%**

Data Source: Utah Insurance Department

Note: Estimates may not add up exactly to totals due to rounding.

Over 99 percent of the total stop-loss membership included some kind of specific attachment point coverage. Nearly 82 percent reported a specific attachment point of $100,000 or more, with about 18 percent reporting a specific attachment point of less than $100,000. About 64 percent of the Small Group (1 to 50) membership had a specific attachment point of $50,000 or less, while nearly 36 percent had a specific attachment point of $100,000. Small Group policies are required to have a specific attachment point of at least $10,000. All (100 percent) of Large Group (51 to 100) membership had a specific attachment point of $100,000 or less. About 84 percent of Large Group (101 or more) membership had a specific attachment point of $100,000 or more. The most common specific attachment points in Large Group (101 or more) membership was $100,000 and $200,000, each of which accounted for about 20.7 percent and 14.7 percent of the stop-loss membership (see Table 31).

Aggregate stop-loss. Aggregate stop-loss protects a self-funded employer group against an unusually high level of excess claim costs that affect the entire employer group. Under a typical stop-loss policy, the aggregate attachment point (also known as an aggregate deductible or aggregate attachment factor) is the threshold at which the stop-loss carrier begins to pay for eligible medical expenses during a given contract period. This threshold, commonly referred to as an aggregate margin, is usually expressed as a percentage of expected claims. For example, an attachment point of 125 percent means the stop-loss coverage starts to pay when the percentage of excess claims reaches 25 percent above the 100 percent of expected claim costs.

Table 32. Stop-Loss Membership by Aggregate Attachment Points for 2021

	Small Group (1 – 50)		Large Group (51 – 100)		Large Group (101 or more)		Total	
Attachment Point	Member Count [a]	Percent of Total	Member Count	Percent of Total	Member Count	Percent of Total	Member Count	Percent of Total
NONE	-	-	5	< 0.1%	223,841	32.3%	223,846	32.3%
85% to 89%	1,113	0.2%	-	-	52,653	7.6%	53,766	7.8%
90% to 94%	-	-	-	-	-	-	-	-
95% to 99%	-	-	-	-	-	-	-	-
100% to 104%	6,204	0.9%	7,298	1.1%	33,408	4.8%	46,910	6.8%
105% to 109%	-	-	-	-	33	< 0.1%	33	< 0.1%
110% to 114%	12,229	1.8%	2,433	0.3%	22,969	3.3%	37,631	5.4%
115% to 119%	160	< 0.1%	-	-	35,747	5.2%	35,907	5.2%
120% to 124%	233	< 0.1%	243	< 0.1%	15,554	2.2%	16,030	2.3%
125% to 129%	5,224	0.7%	4,674	0.7%	263,985	38.2%	273,883	39.6%
130% or more	-	-	118	< 0.1%	3,839	0.6%	3,957	0.6%
Total	**25,163**	**3.6%**	**14,771**	**2.1%**	**652,029**	**94.2%**	**691,963**	**100.0%**

Data Source: Utah Insurance Department

Note: Estimates may not add up exactly to totals due to rounding.

Most (68 percent) of the stop-loss membership included some kind of aggregate stop-loss coverage, with the rest (32 percent) reporting “none”. The most commonly reported aggregate attachment point was between 125% and 129% and accounted for approximately 40 percent of the stop-loss membership, with about 27 percent spread out between 85% to 124%, and less than 1 percent at 130% or more (see Table 32). Small Group policies may not have an aggregate attachment point of less than 85 percent.

Utah's Long-Term Care Insurance Market

Long-term care insurance is designed to provide specialized insurance coverage for skilled nursing care and custodial care in a nursing home, assisted living facility, or at home. Long-term care insurance typically covers specialized services that are not usually covered by comprehensive or major medical health insurance.

Long-term care insurance accounts for approximately 0.5 percent of the commercial health insurance market in Utah (see Table 3). Long-term care insurers provide coverage for about 31,033 members or approximately 1 percent of Utah residents. These estimates only refer to commercial long-term care insurance regulated by the Insurance Department. They do not include other types of long-term care coverage offered by self-funded employers or government programs. This section summarizes various aspects of the market including state of domicile, group size, and age and gender demographics. Enrollment in long-term care insurance is continually declining due to a shift in marketing and product availability. Many insurers are focusing on incorporating long-term care benefits as an option for life insurance policies rather than offering stand-alone products.

Long-Term Care Market by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state. Foreign insurers provide nearly all of Utah's long-term care insurance. Sixty-four foreign insurers account for over 96 percent of the market, with only two domestic insurers providing long-term care coverage (see Table 33). Loss ratios were higher for foreign insurers than for domestic insurers.

Table 33. Total Long-Term Care Market by Domicile for 2021

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	2	700	$1,343,276	3.25%	88.79
Foreign	64	30,333	$39,944,552	96.75%	83.88
Total	**66**	**31,033**	**$41,287,828**	**100.00%**	**84.04**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Long-Term Care Market by Group Size

Long-term care insurance plans are sold either as an individual or a group policy. Individual policies are sold directly to individual consumers. In contrast, group policies are sold as a single contract to a group of individuals, such as a group of employees, or an association plan.

Most long-term care insurers reported individual business, while only 24 companies reported group business. Loss ratios were lower for group policies than for individual policies (see Table 34).

Table 34. Total Long-Term Care Market by Group Size for 2021

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Individual	61	18,549	$34,326,040	83.14%	89.04
Group	24	12,484	$6,961,788	16.86%	59.37
Total	**66**	**31,033**	**$41,287,828**	**100.00%**	**84.04**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

[a] Company count column does not add up to total because an insurer may have more than one group size.

Long-Term Care Market by Age

As Utah's population has grown, the number of individuals over the age of 65 has increased. As we age, the cost of health care, particularly end of life care, increases. As a result, the role of long-term care insurance coverage has grown in importance for older Utah residents.

Long-Term Care membership by age. Commercial health insurers reported 31,033 members with long-term care insurance in Utah during 2021. Nearly thirty-seven percent of the members were under age 65 and over sixty-three percent were sixty-five or older (see Table 35).

Table 35. Long-Term Care Membership by Age for 2021

Age	Member Count	Percent
Age 0-59	8,129	26.2%
Age 60-64	3,214	10.4%
Age 65-69	4,374	14.1%
Age 70-74	4,951	16.0%
Age 75-79	4,258	13.7%
Age 80-84	3,120	10.0%
Age 85+	2,987	9.6%
Total Members	**31,033**	**100.0%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Utah's Medicare Product Market

Medicare Supplement and Medicare Advantage policies are specialized health insurance products designed to complement the federal Medicare program. Medicare Supplement policies are sold as a "supplement" to the basic Medicare Part A (Hospital) and Part B (Medical) programs and provide additional coverage beyond the basic Medicare benefits. Medicare Advantage (also known as Medicare Part C) policies, however, are sold as full replacement products. In other words, instead of providing specialized coverage for the "gaps" in Medicare like a supplementary product (with Medicare still bearing most of the insurance risk), Medicare Advantage products replace Medicare completely and the health insurance company bears the full risk of financial loss.

Another important Medicare product is Medicare Part D. Medicare Part D became available during 2006 as a result of changes to the federal Medicare program. Medicare allows commercial health insurers to offer stand-alone pharmacy coverage via specialized insurance products called Medicare Part D drug plans. These plans provide coverage for prescription drugs, a medical benefit that Medicare Part A and B do not normally pay for. Medicare Part D is also included in many Medicare Advantage policies.

Medicare Supplement and Medicare Advantage products account for 27 percent of Utah's accident & health insurance market, with approximately 2.2 percent of the market share in Medicare Supplement coverage and about 24.8 percent of the market share in Medicare Advantage coverage. Approximately 8.1 percent of Utah residents had coverage under a Medicare Supplement or Medicare Advantage product, with about 2.6 percent in Medicare Supplement product and about 5.5 percent in a Medicare Advantage product. Medicare Part D products account for about 0.7 percent of Utah's accident & health insurance market and provide coverage for approximately 3.3 percent of Utah residents.

These estimates only refer to commercial Medicare products offered in Utah's commercial health insurance market. They do not include other types of Medicare products offered by self-funded employers or government programs. This section summarizes various aspects of the market including state of domicile, age and gender demographics, and plan type.

Medicare Products by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state.

Medicare Supplement by domicile. The majority of Utah's Medicare Supplement coverage is provided by foreign insurers. One hundred and one foreign insurers account for nearly 70 percent of the market, with nine domestic insurers providing the remaining 30 percent (see Table 36). Loss ratios were higher for the foreign insurers than for the domestic insurers.

Table 36. Total Medicare Supplement Market by Domicile for 2021

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	9	24,485	$59,627,080	30.49%	72.71
Foreign	101	61,805	$135,912,906	69.51%	80.38
Total	**110**	**86,290**	**$195,539,986**	**100.00%**	**78.04**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Advantage by domicile. Utah's Medicare Advantage market has more domestic than foreign insurers, with most (82 percent) of the coverage provided by domestic insurers, and the remaining 18 percent provided by foreign insurers (see Table 37). Loss ratios were higher for domestic insurers than foreign insurers.

Table 37. Total Medicare Advantage Market by Domicile for 2021

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	9	151,699	$1,793,255,746	81.90%	86.51
Foreign	8	31,692	$396,228,847	18.10%	81.82
Total	**17**	**183,391**	**$2,189,484,593**	**100.00%**	**85.66**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Part D by domicile. Foreign insurers provide for nearly 94 percent of Utah's Medicare Part D coverage. Domestic insurers provide the remaining 6 percent (see Table 38). Loss ratios were higher for foreign insurers than domestic insurers.

Table 38. Total Medicare Part D Market by Domicile for 2021

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio
Domestic	2	4,233	$4,067,945	6.42%	64.98
Foreign	10	107,041	$59,319,493	93.58%	77.16
Total	**12**	**111,274**	**$63,387,438**	**100.00%**	**76.38**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Products by Age

The number of individuals in Utah over the age of 65 continues to grow. Medicare products, such as Medicare Supplement policies, Medicare Advantage products, and Medicare Part D drug plans are specifically designed for this population, and provide an important type of health care coverage for older Utah residents.

Medicare Supplement membership by age. One hundred and ten commercial health insurers reported 86,290 members with Medicare Supplement coverage. Nearly all (99 percent) of the residents with coverage were over age 65. This is probably due to Medicare's eligibility requirements, which requires most people to be age 65 or older in order to receive coverage (see Table 39). Additionally, Utah does not mandate that insurers offer Medicare Supplement coverage to those individuals who are eligible for Medicare for reason other than age, such as end-stage renal disease.

Table 39. Medicare Supplement Membership by Age for 2021

Age	Member Count	Percent
Age 0-64	1,095	1.3%
Age 65 and Older	85,195	98.7%
Total Members	**86,290**	**100.0%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Advantage membership by age. Seventeen commercial health insurers reported 183,391 members with Medicare Advantage coverage. Most (89 percent) of the residents with coverage were over age 65. This is probably due to Medicare's eligibility requirements, which requires most people to be age 65 or older in order to receive coverage (see Table 40). Additionally, Utah does not mandate that insurers offer Medicare Advantage coverage to those individuals who are eligible for Medicare for reason other than age, such as end-stage renal disease.

Table 40. Medicare Advantage Membership by Age for 2021

Age	Member Count	Percent
Age 0-64	19,433	10.6%
Age 65 and Older	163,948	89.4%
Total Members	**183,391**	**100.0%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Part D membership by age. Twelve commercial health insurers reported 111,274 members with Medicare Part D Drug Plan coverage. Most (90 percent) of the residents with coverage were over age 65. This is probably due to Medicare's eligibility requirements, which requires most people to be age 65 or older in order to receive coverage (see Table 41).

Table 41. Medicare Part D Membership by Age for 2021

Age	Member Count	Percent
Age 0-64	10,943	9.8%
Age 65 and Older	100,331	90.2%
Total Members	**111,274**	**100.0%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Medicare Products by Plan Type

Medicare Supplement membership by plan type. Commercial health insurers reported 86,290 members with Medicare Supplement in Utah during 2021 (see Table 42). Commercial health insurers reported members in one of 17 Standardized Medicare Supplement plans, or in Pre-Standardized plans (plans in force prior to the federal government standardizing the plans that can be offered).

Table 42. Medicare Supplement Membership by Plan Type for 2021

Plan Type	Member Count	Percent
Plan A	445	0.5%
Plan B	193	0.2%
Plan C	1,327	1.5%
Plan D	560	0.6%
Plan E	139	0.2%
Plan F	19,269	22.3%
Plan F (High Deductible Plan)	19,795	22.9%
Plan G	26,753	31.0%
Plan G (High Deductible Plan)	6,383	7.4%
Plan H	225	0.3%
Plan I	192	0.2%
Plan J	783	0.9%
Plan J (High Deductible Plan)	737	0.9%
Plan K	502	0.6%
Plan L	246	0.3%
Plan M	257	0.3%
Plan N	8,336	9.7%
Pre-Standardized Plans	148	0.2%
Total Members	**86,290**	**100.0%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

The most commonly reported Medicare Supplement plan was Plan G with 31.0 percent of the membership. The next closest plans were Medicare Supplement Plan F (High Deductible Plan), with 22.9 percent; Medicare Supplement Plan F, with 22.3 percent; Medicare Supplement Plan N, with 9.7 percent; and Medicare Supplement Plan G (High Deductible Plan), with 7.4 percent All other plans had less than 2.0 percent of the membership (see Table 42). Plans E, H, I, J, and J (High Deductible Plan) were discontinued in 2010. Plans C, F, and F (High Deductible Plan) were discontinued in 2020. These plans are no longer available to new beneficiaries.

Medicare Advantage membership by plan type. Commercial health insurers reported 183,391 members with Medicare Advantage (full Medicare replacement policies) in Utah during 2021. Medicare Advantage plans (which completely replace Medicare and bear the full risk of loss) are available in one of five major plan types.

During 2021, most of the membership was covered under a Health Maintenance Organization plan, with about 77 percent of the membership. The second most common was a Preferred Provider Organization plan, with about 20 percent of the membership. The third most common was a Private Fee-for-Service plan, with about 2 percent of the membership. Medical Savings Accounts and Special Need Plans were the least common, with each accounting for less than 0.4 percent respectively (see Table 43).

Table 43. Medicare Advantage Membership by Plan Type for 2021

Plan Type	Member Count	Percent
Private Fee-for-Service	3,981	2.2%
Preferred Provider Organization	36,761	20.0%
Health Maintenance Organization	141,479	77.1%
Medical Savings Account	355	0.2%
Special Needs Plan	815	0.4%
Total Members	**183,391**	**100.0%**

Data Source: Utah Accident & Health Survey

Note: Estimates may not total exactly due to rounding.

Pharmacy Benefit Manager Rebates

Utah Code § 31A-46-301 and Utah Admin. Code R590-282 requires every licensed pharmacy benefit manager operating in the State of Utah to submit a report to the Insurance Department on or before April 1, 2020, and each year thereafter.

Each licensed pharmacy benefit manager is required to report the total value, in aggregate, of all rebates and administrative fees that are attributable to enrollees of a contracting insurer; and if applicable, the percentage of aggregate rebates that the pharmacy benefit manager retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer.

The Insurance Department is required to publish this information in a manner that does not make a specific submission from a contracting insurer or pharmacy benefit manager identifiable, or disclose information that is a trade secret as defined in Utah Code § 13-24-2 (see Utah Code § 31A-46-301).

There were 40 licensed pharmacy benefit managers operating in Utah during 2021. Below is a summary of the information reported to the Insurance Department for the calendar year 2021 (see Table 44). Among these 40 companies, thirteen companies reported data and were actively doing business in Utah during 2021. Based on these reports, the overall percentage of rebates retained was 5.55 percent.

Table 44. Pharmacy Benefit Manager Rebates and Administrative Fees for 2021

Plan Type	Count	Total Rebates	Total Retained Rebates	Percent Rebates Retained	Total Administrative Fees
PBMs actively doing business	13	$223,332,514	$12,404,259	5.55%	$17,355,789
PBMs that did not report any business	27	$0	$0	0.00%	$0
Total	**40**	**$223,332,514**	**$12,404,259**	**5.55%**	**$17,355,789**

Data Source: Utah Pharmacy Benefit Manager Report

Note: Estimates may not total exactly due to rounding.

Summary

Health insurance is an important issue for the people of Utah. Utah's residents receive their health insurance coverage through health plans sponsored by the government, employers, and commercial health insurers. The commercial health insurance market is the only source of health insurance directly regulated by the Utah Insurance Department, hereafter referred to as the Insurance Department for the purposes of this report.

Approximately 38 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). Comprehensive health insurance membership as a percentage of Utah residents continues to decline and the comprehensive health insurance industry serves about 22 percent of Utah residents. The typical policy in this industry is an employer group policy with a managed care plan administered by a domestic commercial health insurer.

A key function of the Insurance Department is to assist consumers with questions and concerns they have about insurance coverage. The Office of Consumer Health Assistance (OCHA) is the agency within the Insurance Department that handles consumer concerns about their health insurance.

The total number of consumer complaints received by the Insurance Department increased from 2012 to 2016, declined from 2017 to 2020, and then increased during 2021. Consumers continue to contact the Insurance Department in significant numbers. The number of consumer complaints increased during the early implementation of the ACA, but has started to decline towards pre-ACA levels. During 2021, the number of complaints increased by 21 percent. Another important trend over the last seven years has been an increase in the number of complaints related to the issue of balance billing, where a health care provider bills the patient for the difference between the provider's charge and the amount paid by health insurance. Balance billing complaints accounted for about 10 percent of all consumer complaints from 2015 to 2017, about 16 percent during 2018, about 8 percent during 2019, about 10 percent during 2020, and about 6 percent during 2021. In response to this pattern in Utah and other states, the federal government passed the No Surprises Act. This new law addresses the issue of balance billing and provides consumer protections for surprise medical billing. This federal law applies to individual and group health benefit plans and took effect on January 1, 2022.

In addition to consumer complaints, the Insurance Department receives and processes requests from consumers for an independent review of their denied claims by an Independent Review Organization (IRO). The number of independent reviews remained relatively stable from 2012 to 2014, increased during 2015 and 2016, remained stable during 2017, increased during 2018, and then declined during 2019 to 2021. From 2020 to 2021, the number of requests for independent reviews decreased by about 7 percent.

Over the last ten years, there have been four significant trends in the comprehensive health insurance market that the Insurance Department continues to monitor: changes in the number of insurers, the number of Utah residents with comprehensive health insurance, the cost of comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers declined from 2012 to 2020. During 2021, the number of comprehensive health insurers increased. The decline from 2012 to 2020 has primarily been due to a decrease in the number of small and very small foreign comprehensive health insurers. In contrast, while there has been some shifting within the market as part of the full implementation of the ACA including health insurers leaving the market, the total number of large insurers has generally remained stable. Large domestic comprehensive health insurers continue to account for more than 85 percent of the market. The number of medium insurers has fluctuated during this period. Financial stress and regulatory uncertainty in the market have made it difficult for some insurers to participate in the comprehensive market and to sustain participation in the Federally Facilitated Marketplace (FFM). From 2014 to 2021, there has been some market shifting including several new insurers that entered the market to participate in the Federally Facilitated Marketplace (FFM). Recent improvements in premium income and market stability have made it easier for health insurers to participate. Six comprehensive health insurers participated in the FFM during 2021.

From 2012 to 2021, the number of Utah residents covered by comprehensive health insurance as a relative percentage of Utah's population has declined by about 5.4 percent. Comprehensive health insurance membership has averaged about 765,000 members over the last 10 years. During 2021, comprehensive membership increased by about 5.4 percent. This increase appears to be due to changes in the individual and small group markets.

From 2014 to 2016, membership in the individual market grew significantly. Most of this growth was driven by the federal individual mandate which required most persons to maintain health insurance, the availability of coverage through the FFM, where persons whose income is between 100 percent and 400 percent of the federal poverty level receive subsidies to make coverage more affordable, and changes to health insurance regulations, including guaranteed issue and community rating, which have made it easier for Utah residents to get and keep coverage in the individual market.

During 2017, the individual market declined by over 32,000 members. This decline occurred among individuals with Off-Exchange plans who pay the full cost of any premium increases in the individual market and do not receive any subsidies under the ACA to make coverage more affordable. Membership in FFM plans, where most members have premium subsidies, did not experience the same change. Consumers and health insurers were experiencing significant market uncertainty during 2017, such as the question of how rising health care costs and changes to government regulations and the ACA would affect consumers, as well as the ending of Cost-Sharing Reduction (CSR) payments and the possibility of the repeal of the ACA. During 2018, membership in the individual market remained stable, followed by an increase of over 11,000 members during 2019 and 2020. This change appears to be due to steady growth in FFM membership and the availability of enhanced Advance Premium Tax Credit (APTC) payments during this period.

During 2021, membership in the individual market increased significantly. The number of members in the individual market, driven by growth in FFM membership, increased by more than 35,000. This growth appears to be related to the American Rescue Plan Act of 2021 (ARPA). The APRA was designed to assist persons effected by the COVID-19 pandemic, which

includes expanded premium tax credits for individuals who are eligible for the FFM and also offers subsidies to persons with incomes greater than 400 percent of the federal poverty level. The ARPA provisions are temporary and were scheduled to last until the end of 2022 but have been extended through 2025 under the Inflation Reduction Act of 2022.

Membership in the small group market declined from 2016 to 2019. This decline in small group membership followed premium increases in the small group market during this period. It is also possible that some small group membership may have shifted to the individual market, and healthy small groups have moved to self-funded health benefit plan arrangements to circumvent several of the ACA provisions. Small group market membership remained stable during 2020 and then increased during 2021 to a level similar to 2018. The number of members covered by stop-loss policies that were issued to small group self-funded plans increased during this period.

Large group membership declined from 2014 to 2016, remained stable during 2017, and then declined from 2018 to 2021. This change appears to be due to some employer groups moving to self-funding arrangements, although one cannot rule out the possibility of some shifting to the individual market.

Comprehensive health insurance premium per member per month increased slightly from 2020 to 2021. The average premium per member per month increased from $386 during 2020 to $388 during 2021, an increase of 0.5 percent. The small change in premiums was primarily due to comprehensive health insurers setting rates in the individual and small group markets at levels similar to or slightly lower than 2020. Over the last ten years, increases in comprehensive premium per member per month have averaged 5.1 percent per year, while increases in losses per member per month have averaged 5.6 percent per year.

From 2014 to 2016, comprehensive health insurers reported high loss ratios, as premiums, even after payments from the various reinsurance and risk adjustment programs under the ACA, were not sufficient to cover the healthcare costs of their insured members. The shift to ACA compliant plans, changes in rating methods, and expanded coverage for higher risk individuals, combined with lower than expected payments from the federal risk corridor program, all contributed to these higher loss ratios. Comprehensive health insurers in both 2014 and 2015 had limited claim history to work with to produce reasonable projections, were unable to underwrite for insurance risk on an individual basis, and 2014 rates were set prior to the creation of “transitional plans” which prevented insurers from making rate adjustments prior to 2014. During 2016, comprehensive health insurers had more claim experience to work with, but there was still considerable market uncertainty which made pricing their products more difficult. During 2017, health insurers had more accurate pricing information and implemented higher rates that more precisely represented their actual risk experience and this resulted in improved loss ratios in the individual market. During 2018, the combination of more accurate pricing information and the elimination of the CSR payment program by the federal government in October 2017 required health insurers to significantly raise premium rates. The higher premiums collected during 2018 improved loss ratios in the individual market, allowing health insurers to cover the cost of health care services that they were paying out for their members. During 2019,

comprehensive premiums remained stable as comprehensive health insurers maintained the rate increases set during 2018.

During 2020, comprehensive health insurers were impacted by the COVID-19 pandemic. In the spring of 2020, health care spending declined as consumers reduced elective health care to preserve hospital capacity and implement social distancing measures. Although other forms of health care spending increased, the net impact of the COVID-19 pandemic appears to have kept health care spending and comprehensive premiums stable during 2020.

During 2021, comprehensive health insurers experienced uncertainty as to how the COVID-19 pandemic would affect the insurance market. Comprehensive health insurers responded to this uncertainty by setting rates in the individual and small group markets at levels similar to or slightly lower than 2020. Comprehensive health insurers in the individual market reported lower premium per member per month, but experienced higher loss ratios. Comprehensive health insurers in the large group market reported higher premium per member per month, but did not report higher loss ratios.

Comprehensive health insurers, whether for-profit or non-profit, need enough income after expenses to fund state-mandated reserve requirements, reinvest in new equipment and new markets, and acquire and maintain needed capital. The top insurers in the comprehensive health insurance industry have experienced an average financial gain of 2.3 percent in net income after expenses over the last ten years, with top comprehensive health insurers reporting an average gain of 4.0 percent in net income after expenses during 2021.

The first three years of the full implementation of the ACA were financially difficult for Utah's core comprehensive health insurers. Comprehensive health insurers had a limited claim history to work with and were unable to generate enough premium income to cover their losses. Changes to the federal risk corridor program meant comprehensive health insurers did not receive the additional payments that were expected under the program that would have helped them cover their costs.

From 2014 through 2016, the combination of not having enough information to adequately price their products and not receiving the additional payments from the federal risk corridor program as expected produced higher losses for health insurers participating in the individual market and the FFM. Several comprehensive health insurers withdrew from the FFM due to concerns that these losses were not sustainable.

During 2017, the fourth year of the full implementation of the ACA was a mixture of financial and regulatory challenges combined with an increase in financial stability. Regulatory uncertainty such as the possible repeal of the ACA, elimination of the cost-sharing reduction (CSR) payments, and reductions in advertising for the FFM created higher market uncertainty for both consumers and health insurers than would normally have existed under the ACA as written.

During October 2017, the federal government ended the CSR payment program, which required comprehensive health insurers to raise rates higher than they would have been had the CSR payments continued. The combination of higher premium revenue and more accurate pricing information for health insurers led to the beginning of a financial recovery. Comprehensive health insurers reported better financial results during 2017 than they did during the first three years of the full implementation of the ACA, suggesting that health insurers were returning to profitability.

During 2018, the fifth year of the full implementation of the ACA, comprehensive health insurers reported significantly improved financial results. The high losses that were common from 2014 to 2016 were no longer occurring as the large rate increases that were implemented during 2017 and 2018 allowed health insurers to cover the cost of the health care services being provided for their members. The combination of higher premium revenue and more accurate pricing information, particularly in the individual market, has led to a financial recovery. Comprehensive health insurers reported a level of profitability not seen since prior to the full implementation of the ACA.

During 2019, the sixth year of the full implementation of the ACA, premium income stabilized and the financial pattern started in 2018 continued through 2019. The higher premium income helped health insurers cover the cost of health care services that they were paying out for their members. Comprehensive health insurers reported positive financial results for the third year in a row.

During 2020, the seventh year of the full implementation of the ACA, net income increased significantly. This was due to a slight decline in health care spending caused by members delaying or forgoing healthcare treatment due to the COVID-19 pandemic, stable premium income, and a one-time risk corridor payment from the federal government.

During 2021, the eighth year of the full implementation of the ACA, net income declined compared to 2020. Although losses were higher during 2021, premium income remained stable and health insurers were able to cover the costs of their members' health care services. Comprehensive health insurers reported a level of profitability comparable to 2017.

As required by Utah Code § 31A-22-650, the Insurance Department collected data from insurers with a health care preauthorization requirement. This data includes information on the percentage of authorizations for the previous calendar year, not including a claim involving urgent care, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the authorization request. An insurer may not have a preauthorization requirement for emergency health care as described in Utah Code § 31A-22-627. On average, the percentage of health care authorizations processed more than one week after the day on which the insurer received the authorization request was 11.8 percent (see page 15).

As required by Utah Code § 31A-46-301, the Insurance Department collected data from licensed pharmacy benefit managers operating in the State of Utah. This data included the total value of all rebates and administrative fees and the percentage of aggregate rebates that were retained under the pharmacy benefit manager's agreement to provide pharmacy benefits management services to a contracting insurer. Based on these reports, the overall percentage of rebates retained was 5.55 percent (see page 53).

References

American Academy of Actuaries. (2018). Prescription drug spending in the U. S. healthcare system: An actuarial perspective (Issue Brief March 2018). American Academy of Actuaries: Washington, DC.

American Rescue Plan Act. (2021). American Rescue Plan Act of 2021. Public Law No. 117–2. Available at: http://uslaw.link/citation/us-law/public/117/2.

Barnett, J. C., and Berchick, E. R. (2017). Current Population Reports, P60-260, Health Insurance Coverage in the United States: 2016, U.S. Government Printing Office: Washington, DC.

Berchick, E. R., Barnett, J. C., and Upton, R. D. (2019). Current Population Reports, P60-267, Health Insurance Coverage in the United States: 2018, U.S. Government Printing Office: Washington, DC.

Berchick, E. R., Hood, E., and Barnett, J. C. (2018). Current Population Reports, P60-264, Health Insurance Coverage in the United States: 2017, U.S. Government Printing Office: Washington, DC.

Centers for Medicare and Medicaid Services. (2018). Early 2018 Effectuated Enrollment SnapShot. Baltimore, MD: Centers for Medicare and Medicaid Services.

Centers for Medicare and Medicaid Services. (2022a). Early 2022 and Full Year 2021 Effectuated Enrollment Report. Baltimore, MD: Centers for Medicare and Medicaid Services.

Centers for Medicare and Medicaid Services. (2022b). National Health Expenditures 2020 Highlights. Baltimore, MD: Centers for Medicare and Medicaid Services.

Claxton, G., Rae, M., Panchal, N., Whitmore, H., Damico, A., and Kenward, K. (2014). Health benefits in 2014: Stability in premiums and coverage for employer-sponsored plans. Health Affairs, 33 (10), 1851-1860.

Claxton, G., Rae, M., Panchal, N., Whitmore, H., Damico, A., Kenward, K., and Long, M. (2015). Health Benefits in 2015: Stable trends in the employer market. Health Affairs, 34 (10), 1779-1788.

Conway, D., and Branch, B. (2022). American Community Survey Briefs, ACSBR-013, Health Insurance Coverage Status and Type by Geography: 2019 and 2021, U.S. Government Printing Office: Washington, DC.

Hartman, M., Martin, A. B., Benson, J., Catlin, A., and the National Health Expenditure Accounts Team. (2020). National health care spending in 2018: Growth driven by accelerations in Medicare and private insurance spending. Health Affairs, 39 (1), 8-17.

Hartman, M., Martin, A. B., Espinosa, N., Catlin, A., and the National Health Expenditure Accounts Team. (2018). National health care spending in 2016: Spending and enrollment growth slow after initial coverage expansions. Health Affairs, 37 (1), 1-11.

Hartman, M., Martin, A. B., Washington, B., Catlin, A., and the National Health Expenditure Accounts Team. (2022). National health care spending in 2020: Growth driven by federal spending in response to the COVID-19 Pandemic. Health Affairs, 41 (1), 13-25.

Institute of Medicine. (2012). Best care at lower cost: The path to continuously learning health care in America. Washington, DC: National Academies Press.

Kaiser/HRET. (2013). Employer Health Benefits: 2012 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Education Trust.

Kaiser/HRET. (2014). Employer Health Benefits: 2013 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Education Trust.

Kaiser/HRET. (2015). Employer Health Benefits: 2014 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Education Trust.

Kaiser/HRET. (2016). Employer Health Benefits: 2015 Annual Survey. Menlo Park, CA: Kaiser Family Foundation/Health Research and Education Trust.

Kaiser Family Foundation. (2022). Employer Health Benefits: 2021 Annual Survey. San Francisco, CA: Kaiser Family Foundation.

Keisler-Starkey, K., and Bunch, L. N. (2020). Current Population Reports, P60-271, Health Insurance Coverage in the United States: 2019, U.S. Government Printing Office: Washington, DC.

Keisler-Starkey, K., and Bunch, L. N. (2021). Current Population Reports, P60-274, Health Insurance Coverage in the United States: 2020, U.S. Government Printing Office: Washington, DC.

Martin, A. B., Hartman, M., Benson, J., Catlin, A., and the National Health Expenditure Accounts Team. (2016). National health spending in 2014: Faster growth driven by coverage expansion and prescription drug spending. Health Affairs, 35 (1), 150-160.

Martin, A. B., Hartman, M., Lassman, D., Catlin, A., and the National Health Expenditure Accounts Team. (2021). National health care spending in 2019: Steady growth for the fourth consecutive year. Health Affairs, 40 (1), 14-24.

Martin, A. B., Hartman, M., Washington, B., Catlin, A., and the National Health Expenditure Accounts Team. (2019). National health care spending in 2017: Growth slows to post-great recession rates; Share of GDP stabilizes. Health Affairs, 38 (1), 96-106.

No Surprises Act. (2021). No Surprises Act included in the Consolidated Appropriations Act. Public Law No. 116-260. Available at: http://uslaw.link/citation/us-law/public/116/260.

Patient Protection Affordable Care Act. (2010). Public Law No. 111–148 Section 5000A(d)(2)(b). Available at: http://uslaw.link/citation/us-law/public/111/148.

PriceWaterhouseCoopers. (2017). Medical cost trend: Behind the numbers 2018. Washington, DC: PriceWaterhouseCoopers' Health Research Institute.

PriceWaterhouseCoopers. (2018). Medical cost trend: Behind the numbers 2019. Washington, DC: PriceWaterhouseCoopers' Health Research Institute.

Poisal, J. A., Sisko, A. M., Cuckler, G. A., Smith, S. D., Keehan, S. P., Fiore, J. A., Madison, A. J., and Rennie, K. E. (2022). National Health Expenditure Projections, 2021-30: Growth to moderate as COVID-10 impacts wane. Health Affairs, 41 (4), 474-486.

Shrank, W. H., Rogstad, T. L., and Parekh, N. (2019). Waste in the U.S. health care system: estimated costs and potential for savings. JAMA, 322 (15), 1501-1509.

Utah Economic Council. (2022). 2022 Economic Report to the Governor. Salt Lake City, UT: David Eccles School of Business and Governor's Office of Management and Budget.

Utah Insurance Department. (2017). 2018 Utah Rates: Individual and Small Group. Available at: https://le.utah.gov/interim/2017/pdf/00004290.pdf.

Appendix

Recommendations

As requested by the Utah Legislature, the Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market.

1) Consider whether the state should enforce the required provisions of the federal No Surprises Act.

2) Require all insurers offering Medigap insurance to extend product offerings to Medicare recipients who are eligible by disability.

3) Develop and implement effective protocols to prevent disease and improve the health of children through school wellness programs that encourage increased physical activity, nutritional education, and school meals with healthy food choices.

4) Improve education and training on the nature of health care and health insurance costs in State consumer and financial education curriculum standards, with an emphasis on teaching consumers how to spend less and get more value out of their health care purchases.

List of Comprehensive Health Insurers

Table 45. List of Comprehensive Health Insurers during 2021

Company Name	State of Domicile	Direct Earned Premium	Market Share	Loss Ratio
SelectHealth, Inc.	UT	$2,179,766,982	64.24%	86.83
Regence BlueCross BlueShield of Utah	UT	$450,086,985	13.27%	86.58
UnitedHealthcare Insurance Company	CT	$236,132,988	6.96%	76.02
Cigna Health & Life Insurance Company	CT	$138,834,624	4.09%	89.23
University of Utah Health Insurance Plans	UT	$118,953,677	3.51%	100.95
Aetna Life Insurance Company	CT	$89,634,041	2.64%	82.91
Molina Healthcare of Utah, Inc.	UT	$88,425,337	2.61%	99.06
Health Care Service Corporation, a Mutual Legal Re	IL	$26,964,282	0.79%	69.21
UnitedHealthcare of Utah, Inc.	UT	$20,535,169	0.61%	85.50
Aetna Health of Utah, Inc.	UT	$15,949,121	0.47%	87.43
National Health Insurance Company	TX	$10,076,425	0.30%	87.72
WMI Mutual Insurance Company	UT	$4,710,464	0.14%	58.58
State Farm Mutual Automobile Insurance Company	IL	$2,941,197	0.09%	75.58
Humana Insurance Company	WI	$2,457,478	0.07%	62.70
All Savers Insurance Company	IN	$1,899,259	0.06%	127.97
MotivHealth Insurance Company	UT	$1,739,575	0.05%	134.01
Educators Health Plans Life, Accident and Health,	UT	$1,430,421	0.04%	30.88
Educators Mutual Insurance Association	UT	$1,063,403	0.03%	76.09
Angle Insurance Company of Utah dba Angle Health	UT	$462,573	0.01%	77.93
4 Ever Life Insurance Company	IL	$410,640	0.01%	42.56
American National Life Insurance Company of Texas	TX	$283,498	0.01%	142.00
Bridgespan Health Company	UT	$84,999	< 0.01%	47.35
Freedom Life Insurance Company of America	TX	$40,557	< 0.01%	207.81
Metropolitan Life Insurance Company	NY	$21,808	< 0.01%	0.01
Prudential Insurance Company of America	NJ	$21,371	< 0.01%	24.20
American National Insurance Company	TX	$12,422	< 0.01%	170.58
Equitable Financial Life Insurance Company	NY	$11,666	< 0.01%	2.02
Standard Life and Accident Insurance Company	TX	$5,829	< 0.01%	0.58
Transamerica Life Insurance Company	IA	$335	< 0.01%	0.00
All Comprehensive Health Insurers	**29**	**$3,392,957,126**	**100.00%**	**86.66**

Data Source: Utah Accident & Health Survey

List of Health Insurance Mandates in Utah

Coverage Mandates

Required by Federal statute:

1. Dependent coverage from the moment of birth or adoption (31A-22-610)
2. Coverage through a noncustodial parent (31A-22-610.5; Social Security Act)
3. Open enrollment for child coverage ordered by a court (31A-22-610.5; Social Security Act)
4. Medicare supplemental insurance, including preexisting conditions provision (31A-22-620; NAIC Standard; Title XVIII of the Social Security Amendment, 1965)
5. Individual and small group guaranteed renewability (31A-22-618.6; 31A-22-618.7; Health Insurance Portability and Accountability Act, 1997; Patient Protection and Affordable Care Act, 2010)
6. Individual and small group limit on exclusions and preexisting conditions (31A-1-301; 31A-22-605.1; Health Insurance Portability and Accountability Act, 1997; Patient Protection and Affordable Care Act, 2010)
7. Small group portability and individual guaranteed issue (31A-30-108; Health Insurance Portability and Accountability Act, 1997; Patient Protection and Affordable Care Act, 2010)
8. Maternity coverage on groups of 15 or more employees (Pregnancy Discrimination Act, Public Law 95-555, 1978)
9. COBRA benefits for employees of an employer with 20 or more employees (Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, 1985)
10. Preexisting conditions (31A-22-605.1; Health Insurance Portability and Accountability Act, 1997; Patient Protection and Affordable Care Act, 2010)
11. Limitation of annual and lifetime limits for essential benefits (Patient Protection and Affordable Care Act, 2010)
12. Coverage for preventative health services (Patient Protection and Affordable Care Act, 2010)
13. Coverage for children up to age 26, including married children (31A-22-610.5; Patient Protection and Affordable Care Act, 2010)
14. Coverage for individuals participating in approved clinical trials (Patient Protection and Affordable Care Act, 2010)
15. Comprehensive health insurance coverage, coverage of essential health benefits and actuarial value (Patient Protection and Affordable Care Act, 2010)

Required by State statute:

1. Policy provision standards (31A-22-605)
2. Extension of policy for a dependent child with a disability (31A-22-611)
3. Mini-COBRA benefits for employees of an employer with less than 20 employees (31A-22-722)
4. Provisions pertaining to armed forces (31A-22-717)
5. Court order coverage for minor children outside the service area (31A-45-401)
6. Rural health care (31A-45-501)
7. Insurance coverage for autism spectrum disorder (31A-22-642)

Benefit Mandates

Required by Federal statute:

1. Maternity stay minimum limits (31A-22-610.2; Newborn & Mothers Health Protection Act, 1997)
2. Pediatric vaccines – the level of benefit (31A-22-610.5, Omnibus Budget Reconciliation Act, 1993)
3. Catastrophic coverage of mental health conditions and substance abuse (31A-22-625; Mental Health Parity and Addiction Equity Act, 2008)
4. Coverage of emergency medical services (31A-22-627; Federal Patient Bill of Rights Plus Act, Patient Protection and Affordable Care Act, 2010)
5. Mastectomy provisions (31A-22-630; 31A-22-719; Women's Health & Cancer Rights Act, 1996)
6. Alcohol and drug dependency treatment (31A-22-645; Patient Protection and Affordable Care Act, 2010)

Required by State statute:

1. $4,000 minimum adoption indemnity benefit (31A-22-610.1)
2. Coordination of benefits (31A-22-619)
3. Dietary products for inborn metabolic errors (31A-22-623)
4. Access to OB/GYNs, pediatricians as primary care physician (31A-22-624)
5. Diabetes coverage (31A-22-626)
6. Standing referral to a specialist (31A-22-628)
7. Coverage for prosthetic devices (31A-22-638)
8. Cancer treatment parity (31A-22-641)
9. Diagnosis and treatment for autism spectrum disorder (31A-22-642)

Provider Mandates

Required by Federal statute:

None

Required by State statute:

1. Network provider contract provisions (31A-45-303)
2. Managed care organization payments to noncontracting providers in rural areas (31A-45-501)

Statutory Requirements and Methods Overview

Statutory Requirements

Utah Code § 31A-2-201.2 requires that the Utah Insurance Department produce an annual evaluation of the health insurance market. The statutory requirements for this evaluation are shown below:

(1) Each year the commissioner shall:
- (a) conduct an evaluation of the state's health insurance market;
- (b) report the findings of the evaluation to the Health and Human Services Interim Committee before December 1 of each year; and
- (c) publish the findings of the evaluation on the department website.

(2) The evaluation required by this section shall:
- (a) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of the state, and includes an analysis of:
  - (i) the availability and marketing of individual and group products;
  - (ii) rate changes;
  - (iii) coverage and demographic changes;
  - (iv) benefit trends;
  - (v) market share changes; and
  - (vi) accessibility;
- (b) assess complaint ratios and trends within the health insurance market, which assessment shall include complaint data from the Office of Consumer Health Assistance within the department;
- (c) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statues;
- (d) include claims loss ratio data for each health insurance company doing business in the state;
- (e) include information about pharmacy benefit managers collected under Section 31A-46-301; and
- (f) include information, for each health insurance company doing business in the state, regarding:
  - (i) preauthorization determinations; and
  - (ii) adverse benefit determinations.

(3) When preparing the evaluation and report required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

(4) The commissioner may adopt administrative rules for the purpose of collecting the data required by this section, taking into account the business confidentiality of the insurers.

(5) Records submitted to the commissioner under this section shall be maintained by the commissioner as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

Methods Overview

This report primarily uses data from two sources: the NAIC Financial Database and the Utah Accident & Health Survey. It also uses information from national data sources and government agencies. The report will continue to evolve as required to meet the needs of the Utah Legislature.

Qualifications. The accuracy of the information in this publication depends on the quality of the data supplied by commercial health insurers. While the information presented here is believed to be correct and every effort has been made to obtain accurate information, the Insurance Department cannot control for variations in the quality of the data supplied by commercial health insurers or differences in how insurers interpret NAIC and Insurance Department data submission guidelines.

NAIC Financial Database. The NAIC Financial Database is a nationwide database maintained by the National Association of Insurance Commissioners. It contains data obtained from insurance companies' annual financial statements. The data summarizes the total accident & health premium and losses in Utah reported by commercial health insurers to the NAIC.

Utah Accident & Health Survey. The Utah Accident & Health Survey is submitted annually to the Insurance Department. All commercial health insurers are required to file this report. This survey provides detailed information on commercial insurance activity in Utah. It includes information that allows the Insurance Department to estimate trends in Utah's commercial health insurance market, including market share, number of covered lives, loss ratios, and cost of insurance. Data was collected for the years 2012 to 2021.

The survey includes several major components: accident & health insurance, stop-loss insurance, Medicare supplemental insurance, long term care insurance, administration of self-funded plans, as well as comprehensive health insurance. The accident & health insurance portion of the survey must balance to the total accident & health insurance business reported on the Utah business section of the annual statement. The comprehensive insurance section includes detailed information on plan types, group size, and year-end member months. This additional detail allows the Insurance Department to evaluate changes in the comprehensive health insurance market with much greater accuracy.

During 2010, the Utah Accident & Health Survey was reorganized and expanded to include more detailed measures of the comprehensive health insurance market including the Small Employer Defined Contribution Market, analysis of certain types of benefit plans, and measures of certain types of insurance code mandates.

During 2014, the Utah Accident & Health Survey was expanded to include more detailed measures of the comprehensive health insurance market including measures of ACA compliant and Non-ACA compliant plans, and the Federally Facilitated Marketplace (FFM).

The Utah Accident & Health Survey does not specifically measure differences in benefit structure, demographics, or the health status of the commercially insured population. Despite this

limitation, this survey (along with the NAIC Financial Database) is a valuable source of data on Utah's commercial health insurance market and as such provides useful information on commercial health insurance.

Loss Ratios vs MLR. The loss ratios used in this report differ from the NAIC medical loss ratio (MLR) methodology that adjusts for taxes and fees. This report uses the traditional loss ratio methodology, incurred claims divided by earned premium. The MLR methodology is designed for use with comprehensive health insurance business and cannot be applied to all other types of accident & health insurance. Using the traditional loss ratio allows us to compare all types of accident & health insurance.

Health Care Preauthorization Reporting. As required by Utah Code § 31A-22-650, the Insurance Department collects data on health care preauthorizations. Starting in 2020, comprehensive health insurers doing business in Utah are required to annually submit the Utah Adverse Preauthorization Survey to the Insurance Department. This survey provides detailed information on health care authorizations. Data was collected for the years 2020 and 2021.

Utah Pharmacy Benefit Manager Report. As required by Utah Code § 31A-46-301, the Insurance Department collects data on pharmacy drug rebates. Starting in 2019, Pharmacy Benefit Managers licensed in the State of Utah are required to annually submit the Utah Pharmacy Benefit Manager Report to the Insurance Department. This report provides detailed information on pharmacy drug rebates and administrative fees. Data was collected for the years 2019 to 2021.

Glossary

This section includes a brief glossary of some specialized terms used in this report, which may be unclear to readers who are unfamiliar with Utah's health insurance industry.

Commercial health insurance: Any type of accident or health insurance product sold by a commercial health insurer. It refers to any type of accident or health insurance product permitted under the Utah Insurance Code.

Commercial health insurer: An insurance company that is registered with the Utah Insurance Department and is licensed to sell any type of accident or health insurance product in the State of Utah.

Commercial insurance health benefit plan: Another name for comprehensive health insurance. See also Comprehensive health insurance and Comprehensive health insurer.

Comprehensive health insurance: A subset of commercial health insurance. A comprehensive health plan is a general-purpose health insurance product that provides a broad range of insurance coverage for basic medical services typically provided by a physician, including hospital and medical services, and in most cases, durable medical equipment and drugs. Because of the wide variety of basic medical services it covers, these plans are frequently called "major medical", "comprehensive health", or "comprehensive hospital and medical" to distinguish them from other types of accident or health insurance products with more limited benefits. It is the insurance product most people think of when they hear the term "health insurance".

Comprehensive health insurer: A commercial health insurer that offers a comprehensive health insurance product.

Domestic insurer: An insurance company licensed to sell insurance in Utah and which also has its home office in Utah. Insurance companies that have a home office in Utah are said to be "domiciled in Utah". The state of domicile is important because most of the direct regulation of individual insurance companies is done by the state where the company is domiciled (e.g., solvency requirements, etc). See also Foreign insurer.

Employer sponsored self-funded health benefit plan: The key feature of these plans is that the risk of loss is born by the sponsoring organization (e.g., a health benefit plan offered by a large employer or non-profit association group), rather than a commercial health insurer. These plans are exempt from state regulation under the Federal ERISA statute, as they are not considered the "business of insurance", but an employee benefit plan. Self-funded plans are regulated by the Federal Department of Labor and states have no regulatory authority over these plans.

Foreign insurer: An insurance company licensed to sell insurance in Utah, but it does not have a home office in Utah. It is domiciled in another state. See also Domestic insurer.

Government sponsored health benefit plan: Any health benefit plan offered by a federal or state government agency, where the government bears the risk of loss. These plans include

Medicare, Medicaid, Children's Health Insurance Program (CHIP), Primary Care Network (PCN), and the Utah Comprehensive Health Insurance Pool (HIPUtah). The PCN program ended in 2019 and the HIPUtah program ended in 2013. These plans do not include any health benefit plans for government employees, which are considered employer sponsored self-funded health benefit plans. See also Employer sponsored self-funded health benefit plans.